Mercer

Government Human Services Consulting

Puerto Rico Medicaid Program

External Quality Review Technical Report

Contract Year 2023

Puerto Rico

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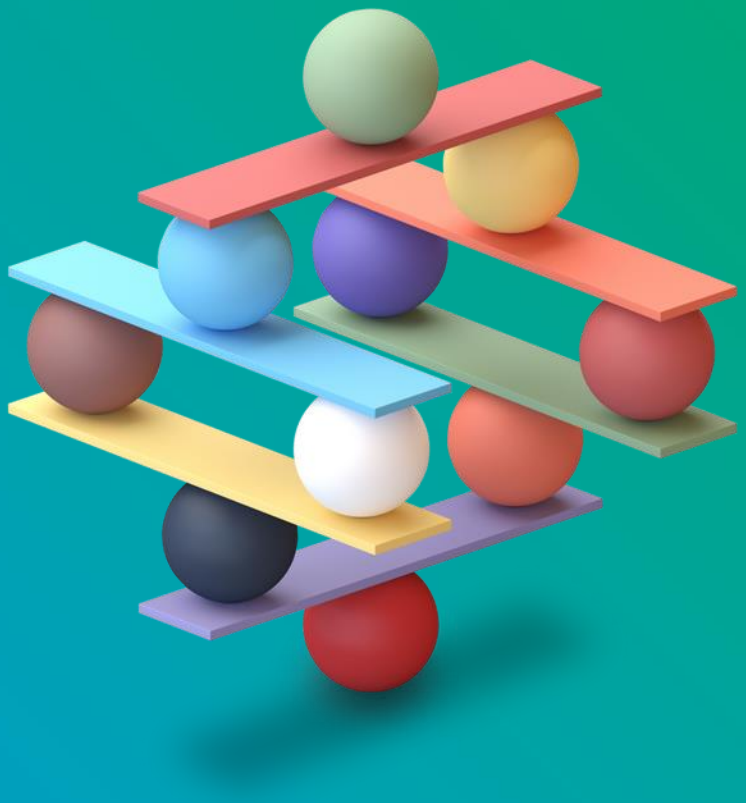


welcome to brighter

A business of Marsh McLennan

Contents

Section 1
Introduction

The Balanced Budget Act of 1997 (BBA) was an omnibus legislative package enacted by the United States Congress with the intent of balancing the federal budget by 2002. Among its other provisions, this expansive bill authorized states to provide Medicaid benefits (except to special needs children) through managed care plans. Regulations were promulgated, including those related to the quality of care (QOC) and service provided by managed care plans to Medicaid beneficiaries. An associated regulation requires that an External Quality Review Organization (EQRO) conduct an analysis and evaluation of aggregated information on quality, timeliness, and access to the healthcare services that a managed care plan or its contractors furnish to Medicaid recipients. The EQRO creates plan specific reports and as part of its analysis and evaluation activities, the EQRO is required to submit a technical report to the state Medicaid agency, which in turn submits the report to the Centers for Medicare & Medicaid Services (CMS). The report is also posted to the Medicaid agency website.

The Government of Puerto Rico Medicaid Program (PRMP) entered into an agreement with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to perform External Quality Review (EQR) services related to its Medicaid program. All Puerto Rico Managed Care Organizations (MCOs)/Government Health Plans (GHPs), and Platino Medicare Advantage Organizations (MAO)/Platino, collectively referred to as Managed Care Plans (MCPs) participate in the EQR. MCO/GHP reviews include First Medical Health Plan, Inc (FMHP), MMM Multi Health, LLC (MMM), Plan de Salud Menonita (PSM), and Triple-S Salud (Triple-S). MAO/Platino plans reviewed include Humana Health Plans of Puerto Rico, Inc. (Humana), Medical Card System (MCS), MMM Platino, and Triple-S Platino.

Scope of the External Review Process

Mercer conducted a retroactive and current review of the following EQR activities for Puerto Rico's MCPs:

EQR Activity	Description	Plans Reviewed
Protocol 1	Performance Improvement Plan (PIP) validation for PIPs underway during calendar year (CY) 2023	GHPs
Protocol 2	Performance measure (PM) validation for PMs calculated using data from CY 2023, including an Information Systems Capability Assessment (ISCA)	GHPs
PM Rate Reporting	PM rate reporting	GHP Platino Plans

EQR Activity	Description	Plans Reviewed
Protocol 3	Corrective Action Plan (CAP) review of compliance with federal standards and contract requirements related to member access to timely, quality healthcare during CY 2023	GHPs Platino Plans
Protocol 4	Validation of CY 2023 Network Standards	GHPs

Section 2

EQR Overview

EQR Objectives

Mercer's objective for the EQR was to assess Puerto Rico health plan performance toward achieving Puerto Rico's Quality Strategy goals, which are:

- To improve preventative care screening, access to care, and utilization of health services for all Medicaid, federal and state, and Children's Health Insurance Program (CHIP) Enrollees.
- To improve Enrollee satisfaction with provided services and primary care experience.

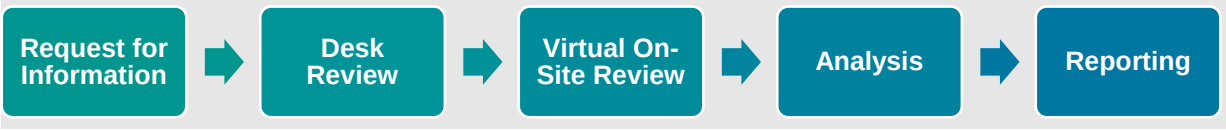
To achieve this objective, Mercer performed the mandatory EQR activities which are intended to improve Puerto Rico's ability to oversee and manage the contracted health plans and help improve their performance with respect to quality, timeliness, and access to care. The mandatory activities for CY 2023 included validation of PIPs, validation of PMs, validation of Network Adequacy, and a compliance CAP review of Medicaid and CHIP managed care regulations. This report presents the results as required by 42 CFR 438.364. The objectives of this review included:

- Assessing the quality of services provided, the timeliness of services provided, and access to care and recommendations to the MCOs, MAOs, and Puerto Rico for continued improvement.
- Validation of MCO PIPs, PMs, and Network Adequacy.
- Assessing implementation of CAP activities.

Technical Methods for Data Collection and Analysis

As a consulting firm, Mercer has access to individuals with expertise in a variety of fields. For this EQR process, Mercer chose a specifically designated team with a variety of specialties and talents that could meet the requirements of the EQR process.

The methodology used by Mercer, during this review process, was organized into five critical phases presented in the following diagram.



Request for Information

Mercer utilized a request for information (RFI) to acquire information specific for all areas of the review. Mercer received information electronically and reviewed all documents submitted over a series of weeks. The information was organized on the SharePoint site into folders and subfolders, coordinating with the data request format. During the virtual review phase,

additional information was collected; a small number of outstanding data needs remained. At the close of the virtual review process, Mercer summarized the outstanding information needs and the MAOs and MCOs submitted additional information for further review and consideration following the virtual visits.

Review Tool

Mercer utilized a comprehensive EQR compliance review tool (tool) adapted from CMS protocols for the compliance section of the review. The tool design included state standards reflecting key issues and Puerto Rico priorities. Additionally, the tool assisted the reviewers in coordinating the review process in a logical manner, consistent with the flow of BBA regulations. Mercer's desk review results helped to focus observations and interviews to gather additional information during the virtual review phase. The review tool for CY 2023 included only CAP areas for review in CY 2023.

Analysis and Reporting

Information from all phases of the review process was gathered, and analysis was completed. Each EQR activity includes a scoring section which is defined in that section of the report.

Description of the Data Obtained

The data obtained for the annual review included, but was not limited to:

- Organizational charts, staffing locations, and staffing plans
- Delegated arrangements
- Staff orientation, training plans, and handbook
- CAPs and supporting documentation
- Provider and Enrollee satisfaction survey results
- Documentation and data used to support ISCA and validation of PIPs, PMs, and Network Adequacy
- Healthcare Effectiveness Data and Information Set (HEDIS®) audit documentation and results

In addition to the documentation reviewed, Mercer conducted interviews with MCP staff to assess consistency of responses across operational areas and documentation the health plan provided.

Conclusions Based on the Data Analysis

Mercer's reviewers used analytic questions such as those noted below during their review of the various EQR activities:

- PIP Validation: Did the MCO develop a PIP Aim Statement that was clear, concise, measurable, and answerable? Did the MCO clearly identify the population targeted for the PIP? Did the MCO use appropriate sampling methods? Did the MCO use appropriate

variables to identify the performance of the PIP? Did the MCO incorporate a data collection plan specifying the data sources, data collected, how and when data is collected, cadence of data collection, staff responsible for collecting the data, and the instruments used to collect the data? Did the MCO implement a continuous QI process for analysis and interpretation of the PIP?

- PM Validation: How are PM data collected? Where are data used for PM stored? What are the sources for data used for PM calculation? How often are data exchanged with vendors supplying supplemental data? How are the files for HEDIS vendor software created and what controls are in place in to ensure the merged data files are accurate and complete? What processes are implemented to prevent loss of data when systems fail? What are your processes for preliminary rate calculations and how are they monitored? How does the MCP address changes to measures? If hybrid data collection methods are used, is collection done in-house or outsourced? What training is provided to abstractors? What are the processes to ensure inter-rater reliability (IRR)? What are the MCP processes for vendor oversight and monitoring?
- Compliance Validation: Did the MCP supply CAP documentation evidencing compliance with regulatory and contractual requirements? Were the CAP interventions sufficient to gain compliance and operationalize changes? Did staff interviews demonstrate consistency with compliance?
- Network Adequacy Validation: Did the MCO define the Network Indicator correctly? What data sources are used? How does the MCO validate results? Were any data concerns identified?

Section 3
Validation of PIPs

Introduction

PIPs are required by CMS as an essential component of a MCO's quality program and are used to identify, assess, and monitor improvement in processes or outcomes of care. The objective of the validation process is to assess overall project methodology as well as the overall validity and reliability of the PIP methods and findings to determine confidence in the results. PIPs are validated in accordance with § 438.330 using the analytic approach established in CMS EQR Protocol 1. As required by CMS, Mercer is providing project-specific summaries using CMS Worksheet Number 1.11 from EQR Protocol 1, Validation of PIPs. The PIP Aim Statements are taken directly from the MCO's report(s) to Mercer, as are the improvement strategies, interventions, and performance indicator data. Mercer validated each of these projects, meaning that it reviewed all relevant parts of each PIP and made a determination as to its validity. Reviewers assigned a validation confidence rating, which refers to Mercer's overall confidence that the PIP adhered to acceptable methodologies for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of improvement or the potential for improvement. Recommendations offered were taken from the reviewers' rating forms. As is required by CMS, Mercer has identified MCO project strengths as evidenced in the PIP. It should be noted that the Platino MAOs were not required to implement PIPs, therefore are not included in this review section.

Puerto Rico has mandated the following PIPs for its GHPs in CY 2023.

Topic
1. One clinical care project in the area of improving kidney health evaluation rates in order to identify early stages of decreased kidney function. The PIP must use, but is not limited to, HEDIS measure Kidney Health Evaluation for Patients with Diabetes (KED) measure as one of the PIP PMs.
2. One clinical care project in the area of increasing screening for depression, anxiety, substance use disorders for all covered populations using nationally recognized screening tools (e.g., Beck Depression Inventory, PHQ-2, PHQ-9, CRAFFT, CAGE-AID, Depression Scale for Children, GAD-7, DAST, ACES, and ASAM).
3. One clinical care project designed to improve outcomes for Enrollees with diabetes that includes but is not limited to, HEDIS measure Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (<9.0%) as one of the PIP PMs.
4. One administrative project designed to improve EPSDT screening rates.
5. One administrative project to increase use of reverse co-location and co-location of physical and behavioral health (BH) and their integration.

Review Process

Methodology

The summary results and recommendations presented below are based on EQR PIP Validation Protocol 1. Validation of PIPs which includes:

- Review the Selected PIP Topic
- Review the PIP Aim Statement
- Review the Identified PIP Population
- Review the Sampling Method
- Review the Selected PIP Variables and PMs
- Review the Data Collection Procedures
- Review Data Analysis and Interpretation of PIP Results
- Assess the Improvement Strategies
- Assess the Likelihood that Significant and Sustained Improvement Occurred

The EQRO provides an overall validation rating of the PIP results. The validation rating refers to the EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results, and produced evidence of improvement.

Confidence in Reported Results			
High	**Moderate**	**Low**	**No Confidence**
Fully compliant with standard protocol.	Substantially validated and only minor deviations from standard protocol.	Deviated from protocol such that the reported results are questionable.	Deviated from protocol such that reported results are not validated.

Findings by MCO

Overall, the MCOs submitted PIPs demonstrating commitment to aligning with Puerto Rico's improvement projects, and when optimal, used HEDIS metrics, adhering to National Committee for Quality Assurance's (NCQA's) HEDIS Technical specifications. PIP Aim Statements, analyses, and data collection processes continue to be addressed by the MCOs as well as the analysis for statistical significance in improvement.

FMHP

FMHP has revised their PIP structures to better align with CMS guidance for design, data collection, analysis, and interpretation. The PIP Aim Statements define the population and time period for evaluation with an indication for general improvement in the PIPs. For most PIPs, the Aim Statements have the opportunity for further refinement by including an overarching improvement strategy, following CMS Protocol 1 Guidelines for Aim Statement

Development. FMHP also had the opportunity to include additional information in PIP program documents and work plans for all phases of PIP implementation and evaluation (e.g., outcome analysis, plan, do, study, act activities, timeline and results, lessons learned and how they are incorporated into the PIP, reporting dates, numerator, and denominators, etc.).

MMM

MMM has revised their PIP structures to better align with CMS guidance for design, data collection, analysis, and interpretation. The PIP Aim Statements clearly identified the strategy, population, and time period. Analysis and Interpretation of PIP results were also included as well as analysis for statistically significant changes. Overall, the PIPs were well designed and showed improvement in the first re-measurement year. Recommendations are provided for each PIP below; however, Mercer also recommends that MMM provide complete and comprehensive responses within the RFI with future reviews. The RFI is developed to acquire responses from the MCOs to identify very specific aspects of PIP projects that are required by CMS.

PSM

Overall, PSM provided well developed PIPs, including PIP Aim Statements defining the goals, population, and time period for evaluation. PSM continued to demonstrate alignment with PRMP initiatives as well as Health and Human Services (HHS) and CMS priority areas, including the use of CMS child and adult core set measures when applicable. PIP improvement strategies often included Enrollee outreach, sending list to providers of Enrollees in need of services, provider education, and gaps in care reports. It is notable that PSM, however, did not provide evidence of the CY 2023 data, preventing analysis for improvement. During the on-site review, PSM indicated that PIPs were implemented for CY 2023 and therefore, re-measurement would not be available, despite PIP documents indicating an earlier baseline year.

Triple-S

Generally, Triple-S delivered PIPs identifying membership population, PIP goals and improvement targets, and time period for expected improvement. Triple-S incorporated the use of HEDIS measures and engaged HEDIS-certified vendors with some of the PIPs. Triple-S has the opportunity to incorporate CMS EQR Protocol guidelines with PIP development, including Aim Statements, identifying variables, monitoring for gaps in measures, and outlining improvement strategies. Additionally, it is recommended that Triple-S adopt a standardized process for PIP development, implementation, and evaluation to ensure PIPs are following a consistent methodology for all phases of design and data collection and conducting accurate data analysis and interpretation of PIP results. Lastly, the opportunity exists for Triple-S to develop a data collection plan and data analysis plan, clearly defining the method for collecting data, frequency of data collection, data sources, data elements, and data collection instruments for every PIP.

Comparative Analysis

GHP PIP Confidence Ratings for Adherence to Acceptable Methodology for All Phases by Project Topic

Plan	Improving Kidney Health Evaluation Rates	Increasing Screening for Depression, Anxiety, and/or SUD	Improving Outcomes for Enrollees with Diabetes	Improving EPSDT Screening Rates	Increasing Use of Reverse Co-Location and Co-Location of Physical and BH
FMHP	Moderate Confidence	Moderate Confidence	Moderate Confidence	Moderate Confidence	Moderate Confidence
MMM	High Confidence	High Confidence	High Confidence	High Confidence	High Confidence
PSM	Moderate Confidence	Moderate Confidence	Moderate Confidence	Moderate Confidence	Moderate Confidence
Triple-S	Moderate Confidence	Moderate Confidence	Moderate Confidence	Moderate Confidence	Low Confidence

GHP PIP Confidence Ratings for Evidence of Significant Improvement by Project Topic

Plan	Improving Kidney Health Evaluation Rates	Increasing Screening for Depression, Anxiety, and/or SUD	Improving Outcomes for Enrollees with Diabetes	Improving EPSDT Screening Rates	Increasing Use of Reverse Co-Location and Co-Location of Physical and BH
FMHP	NA: Baseline CY 2023	NA: Baseline CY 2023	NA: Baseline CY 2023	NA: Baseline CY 2023	Low Confidence
MMM	High Confidence	High Confidence	Low Confidence	High Confidence	High Confidence
PSM	Low Confidence	Low Confidence	Low Confidence	Low Confidence	Low Confidence
Triple-S	NA: Baseline CY 2023	NA: Baseline CY 2023	NA: Baseline CY 2023	NA: Baseline CY 2023	Low Confidence

Plan-Specific PIPs

Topic 1: Improving Kidney Health Evaluation Rates

FMHP

Topic 1: Improving Kidney Health Evaluation Rates (FHMP)
1. General PIP Information
MCO Name: FMHP
PIP Title: Improving of Kidney Health Evaluation Rates: Caring my Kidney Project
PIP Aim Statement: Achieve an improvement (any) in kidney health evaluation rates and related measures in diabetic population of 18 to 85 years considered at risk for Kidney Chronic Disease stage 1 or stage 2 for 2024 and 2025 using as a baseline the 2023 results of the measures identified for this PIP.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ☐ Other: Target age group not identified ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, long-term services, and support (LTSS), or pregnant women (please specify): Adults at risk for Kidney Chronic Disease stage 1 or stage 2.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
2. Improvement Strategies or Interventions
• Identify Enrollees with diabetes diagnosis and abnormal laboratories for HgA1c • Education approach to patients • Mailing education material to targeted Enrollees • Phone calls for patient coaching • Encourage preventive medical evaluations with PCP and specialists according to the beneficiaries needs • Mailing education material to targeted providers • Monitor program activity and outcomes based on achievement thresholds • Revision or development of PIP reports to provide updates on the PIPs interventions/results

Topic 1: Improving Kidney Health Evaluation Rates (FHMP)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Kidney Health Evaluation Rate for members 18–85 years of age with diabetes who received both an estimated glomerular filtration rate (eGFR) and urine albumin-creatinine (uACR) during the measurement year (KED) NCQA-HEDIS.	CY 2023	Numerator/ Denominator not provided, Rate: 12.05 %	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Hemoglobin A1c Control for Patients with Diabetes (HBD) (Poor Control) NCQA-HEDIS/ CMS Adult Core Set	CY 2023	Numerator/ Denominator not provided, Rate: 84.43 %	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PQI: 01 Diabetes Short-Term Complications Admission Rate. AHRQ	CY 2023	Numerator/ Denominator not provided, Rate: 71	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
ER Visit Rate for Members 18–85 years with Diabetes and Hypertension	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 1: Improving Kidney Health Evaluation Rates (FHMP)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Hospital Admissions & Readmissions for Members 18–85 Years with Diabetes	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 1: Improving Kidney Health Evaluation Rates (FHMP)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year
☐ First re-measurement ☐ Second re-measurement ☐ Other (specify): Sixth re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ NA: Baseline year

Topic 1: Improving Kidney Health Evaluation Rates (FHMP)

MCO strengths:

The FMHP PIP included a clear Aim Statement outlining evaluation rates to be measured, with the population and evaluation time period defined. The PIP program document provides a comprehensive background describing the necessity for the PIP and clearly defines the objectives. FMHP used nationally recognized measures to ensure consistent data collection procedures and included Enrollees and providers in monitoring and result discussions at Quality Advisory Board meetings.

EQRO recommendations:

- Include strategy intended to improve outcomes within the PIP Aim Statement.
- Develop a comprehensive work plan detailing all requirements and phases and methodology for PIP development, implementation, and evaluation, as well as all activities associated with the PIP.
- Develop a comprehensive data collection plan for each metric, including process to collect data, identifying sources and technical specifications, as well as incorporation of analysis for statistical significance in reported data for each metric.
- Provide all data when reporting (e.g., rate and numerator/denominator).
- Provide process for selecting improvement strategy, including explanation how strategy will likely lead to improvement.
- Develop data analysis plan, outlining continuous quality improvement processes and expected cadence. Include description of processes to evaluate interventions, gaps in measures, and actions taken based on evaluation.
- Consider inclusion of Enrollee satisfaction and/or experience of care as a result of PIP activities.
- Consider inclusion of culturally or linguistically appropriate strategies for the PIP population.
- Outline personnel and qualifications for data collection.

MMM

Topic 1: Improving Kidney Health Evaluation Rates (MMM)

1. General PIP Information

MCO Name: MMM

PIP Title: Improving Kidney Health Among Beneficiaries of MMM Multi Health

PIP Aim Statement: Will interventions with providers and beneficiaries focused in managing risk in beneficiaries at risk of kidney disease improve kidney health screening and blood pressure control over a three-year period?

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):

☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Topic 1: Improving Kidney Health Evaluation Rates (MMM)

Target age group (check one):
☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children
☐ Other: Target age group not identified.
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, long-term services and support (LTSS), or pregnant women (please specify):
Members with diabetes (type 1 and type 2) and/or hypertension (HTN).

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Member education activity
- One page Kidney Health educational material developed for face-to-face interventions with providers
- Provider education monthly activity
- Presentation at the Advisory Board

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
NCQA – HEDIS: Kidney Health Evaluation for Patients with Diabetes (KED)	CY 2022	4,771/25,723 (18.55%)	CY 2023 Q3 (10/01/2022–09/30/2023)	6,522/25,161 (26%)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):
NCQA – HEDIS: Controlling High Blood Pressure (CBP)	CY 2022	9,689/20,709 (46.79%)	CY 2023 Q3 (10/01/2022–09/30/2023)	11,698/21,148 (55.31%)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☐ <.01 ☒ <.05 Other (specify):

Topic 1: Improving Kidney Health Evaluation Rates (MMM)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Topic 1: Improving Kidney Health Evaluation Rates (MMM)
Validation phase (check all that apply): ☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year ☒ First re-measurement ☐ Second re-measurement ☐ Other (specify): Sixth re-measurement **Validation rating # 1**: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results. ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence **Validation rating # 2:** EQRO's overall confidence that the PIP produced significant evidence of improvement. ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
MCO strengths: MMM provided a well-developed PIP including all phases of design and data collection. The PIP Aim Statement clearly identified the strategy, population, and time period. Analysis and Interpretation of PIP results were included. **EQRO recommendations**: • Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation. • Identify processes in place to identify gaps in measures when needed. • Expand on the use of HEDIS technical specifications within the system and processes to ensure most recent specifications are used on a regular cadence. • Expand on analysis of improvement strategies (e.g., intervention effectiveness, and quarterly reporting of these analyses). • Widen the strategy to include additional member-specific interventions. • Identify internal processes implemented as interventions (e.g. new programs, practices, or infrastructure, such as new patient registries or data tools).

PSM

Topic 1: Improving Kidney Health Evaluation Rates (PSM)
1. General PIP Information
MCO Name: PSM
PIP Title: KED Performance Improvement Project
PIP Aim Statement: By CY 2024 PSM will increase the annual rate of Kidney Health Evaluation for Diabetics (KED) that are 18–85 years of age, at or above 3% of PSM 2022 KED benchmark.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).

Topic 1: Improving Kidney Health Evaluation Rates (PSM)

Target age group (check one):
☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children
☐ Other: Target age group not identified.
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, long-term services and support (LTSS), or pregnant women (please specify):
All Medicaid eligible adults that are 18–85 years of age with diabetes (type 1 and type 2).

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Care manager outreach to members with chronic conditions with a gap in KED screening
- Text messaging, promoting early screening
- Send list of members without screening for KED
- Development of gaps in care report

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
NCQA – HEDIS: Kidney Health Evaluation for Patients with Diabetes (KED)	CY 2022	1,813/12,776 (14.2%)	Not Provided	Not Provided	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not Reported

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☒ First re-measurement ☐ Second re-measurement ☐ Other (specify): Sixth re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.
☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.
☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Topic 1: Improving Kidney Health Evaluation Rates (PSM)
MCO strengths: PSM has a well-organized PIP work plan identifying all phases of design and data collection, key factors for implementing and monitoring improvement plans. PIP Aim Statement was clear and defined the goal, population impacted, and time period for evaluation. **EQRO recommendations**: • Include strategy intended to improve outcomes within the Aim Statement. • Include the data reporting for CY 2023 and utilize the quarterly reporting of outcome data in PDSA process. • Include definition of continuous enrollment. • Include role and qualifications of data collection personnel. For example, is the QA Director, tasked with evaluating outcomes, also the individual who is responsible for validating the HEDIS vendor reporting (i.e., using the Data Validation Process P&P), and what are the qualifications of the individual? • Describe processes to identify gaps in measures for PIP population as well as process to validate information obtained from HEDIS vendor. • Include all improvement strategies and/or interventions implemented. • Provide an analysis or interpretation of data outcomes and improvement strategies. • Describe processes to identify gaps in measures for PIP population. • Widen the strategy to include additional evidence-based interventions. • Include Enrollees and/or providers in evaluation of interventions.

Triple-S

Topic 1: Improving Kidney Health Evaluation Rates (Triple-S)
1. General PIP Information
MCO Name: Triple-S
PIP Title: Kidney Health Evaluation for Patients with Diabetes
PIP Aim Statement: Increase KED Measure result by 2.5% by the end of MY2023 and an additional 2.5% by the end of MY2024 for the HEDIS eligible population. Increase the percentage of adults with CKD (age 18–85) with a completed HRA, Renal Assessment and Nutritional Assessment in Care management. Increase the percentage of adults of Enrollees with CKD 3,4, & 5 to have at least two annual visits to the nephrologist. Orient 10% of the enrollees on the “Mas Allá de tus Riñones " program.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).

Topic 1: Improving Kidney Health Evaluation Rates (Triple-S)

Target age group (check one):
☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ☐ Other: Target age group not identified.

***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, long-term services and support (LTSS), or pregnant women (please specify):
Enrollees age 18 to 85 years diagnosed with CKD 3,4, 5 in claims.

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

None Provided

Topic 1: Improving Kidney Health Evaluation Rates (Triple-S)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
NCQA – HEDIS: Kidney Health Evaluation for Patients with Diabetes (KED)	CY 2023	Numerator/ Denominator not provided, Q3 Rate: 25.54%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Adults with CKD (age 18-85) with a completed HRA	CY 2023	Numerator/ Denominator not provided Q3 Rate: 18%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Adults with CKD (age 18-85) with a renal assessment	CY 2023	Numerator/ Denominator not provided Q3 Rate: 1%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 1: Improving Kidney Health Evaluation Rates (Triple-S)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Adults with CKD (age 18-85) with a nutritional assessment	CY 2023	Numerator/ Denominator not provided Q3 Rate: 2%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Adults with CKD 3, 4, & 5 with two visits with Nephrologists, annually	CY 2023	Numerator/ Denominator not provided, Q3 Rate: 3%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Population with ESRD (with or without dialysis) enrolled in educational program "Mas alla de tus rinones"	CY 2023	Numerator/ Denominator not provided Q3 Rate: 25.54%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 1: Improving Kidney Health Evaluation Rates (Triple-S)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year
☐ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ N/A Baseline Year

Topic 1: Improving Kidney Health Evaluation Rates (Triple-S)
MCO strengths: Triple-S has a well-structured PIP document identifying key factors for implementing and monitoring improvement plans. Triple-S provided a list of goals similar to an aim statement, including improvement goal and time period with general reference to population (HEDIS eligible population). **EQRO recommendations**: • Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation. • Clearly indicate PIP is for Medicaid line of business. • Identify Aim Statements in PIP as the Aim Statement and include improvement strategy, following CMS EQR Protocol guidance for developing PIP Aim Statements. • Develop a data collection plan and data analysis plan, clearly defining the method for collecting data, frequency of data collection, data sources, data elements, and data collection instruments for every PIP. • Provide all outcome data for each metric in the PIP. • Describe processes to identify gaps in measures for PIP population. • Include an improvement strategy with PIP development, indicating actions the MCO plans to implement to improve outcomes. • Provide an analysis or interpretation of data outcomes and improvement strategies. • Include Enrollees and/or providers in evaluation of interventions. • Include role and qualifications of data collection personnel.

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD

FMHP

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (FMHP)
1. General PIP Information
MCO Name: FMHP
PIP Title: Increasing Screening for Depression, Anxiety, Substance Use Disorder
PIP Aim Statement: Achieve the increase of screenings (any increase) rates for Depression, Anxiety, Substance Use for the population of 18 years or older responding the Screening Tools PHQ 9 (for depression), GAD 7 (anxiety), and CAGE – AID (drug and alcohol use disorder) as established in the article 12 of the ASES contract for 2024 and 2025 using a baseline the FMHP 2023 results of the measures identified for this PIP.

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (FMHP)

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):
☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):
☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
Members 18 years or older responding the Screening Tools PHQ 9, GAD 7, and CAGE – AID as established in the article 12 of the ASES contract.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Educational activities to target members with finding in the screenings
- Educational activities for providers regarding PIP and QAPI program
- Developed screening tool templates
- Monitor program activity and outcomes based on achievement thresholds
- Revision or development of PIP reports to provide updates on the PIPs interventions/results

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (FMHP)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Rate of screenings for depression (PHQ-9) performed for FMHP beneficiaries 18 years and older.	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Rate of screenings for anxiety (GAD-7) performed for FMHP beneficiaries 18 years and older.	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (FMHP)						
Rate of screenings for substance use (CAGE AID) performed for FMHP beneficiaries 18 years and older.	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year
☐ First re-measurement ☐ Second re-measurement ☐ Other (specify): Third re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ NA: Baseline year

MCO strengths:

The FMHP PIP included a clear Aim Statement outlining evaluation rates to be measured, with the population and evaluation time period defined. The PIP program document provides a comprehensive background describing the necessity for the PIP and clearly defines the objectives. FMHP also included Enrollees and Providers in monitoring and result discussions at Quality Advisory Board meetings.

EQRO recommendations:

- Include strategy intended to improve outcomes within the Aim Statement.
- Develop a comprehensive work plan detailing all requirements and phases and methodology for PIP development, implementation, and evaluation, as well as all activities associated with the PIP.
- Develop a comprehensive data collection plan for each metric, including process to collect data, identifying sources and technical specifications, as well as incorporation of analysis for statistical significance in reported data for each metric.
- Provide all data when reporting (e.g., rate and numerator/denominator).
- Provide process for selecting improvement strategy, including explanation how strategy will likely lead to improvement.

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD
• Develop data analysis plan, outlining continuous quality improvement processes and expected cadence. Include description of processes to evaluate interventions, gaps in measures, and actions taken based on evaluation. • Consider inclusion of Enrollee satisfaction and/or experience of care as a result of PIP activities. • Consider inclusion of culturally or linguistically appropriate strategies for the PIP population. • Outline personnel and qualifications for data collection.

MMM

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (MMM)
1. General PIP Information
MCO Name: MMM
PIP Title: Performance Improvement Project to increase screening for depression, anxiety, and substance use disorder.
PIP Aim Statement: Will the orientation to providers and members implemented improve the screening for depression and follow-up plan among beneficiaries aged 12 and older over a three-year period?
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Members aged 12 and older who have never had a diagnosis of depression or bipolar disorder.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
2. Improvement Strategies or Interventions
• Promotion of "My Emotions" icon at the MMM app • Meetings with Mental Health Clinics • Coordination for information sharing by Mental Health (MH) clinics and by MH and Health Services Case Management • Distribution and orientation/awareness of screening tools • Presentations in the Advisory Board on specific themes (e.g., MH screenings in primary care setting, early identification, and risk factors)

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (MMM)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
CMS Adult Core Set: CDF-AD Screening for depression and follow-up plan, ages 18 and older	CY 2022	3,734/112,606 (3.32%)	CY 2023 Q3 (10/01/2022–09/30/2023)	7,213/123,741 (5.91%)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):
CMS Child Core Set: CDF-CH Screening for depression and follow-up plan, ages 12–17	CY 2022	900/14,412 (6.2%)	CY 2023 Q 3 (10/01/2022–09/30/2023)	1,618/15,893 (10.18%)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☒ First re-measurement ☐ Second re-measurement ☐ Other (specify): Third re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (MMM)
MCO strengths: MMM provided a well-developed PIP including all phases of design and data collection. The PIP Aim Statement clearly identified the strategy, population, and time period. Analysis and Interpretation of PIP results were included. **EQRO recommendations:** • Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation. • Identify processes in place to identify gaps in measures when needed. • Expand on the use of Core Set technical specifications within the system and processes to ensure most recent specifications are used on a regular cadence. • Expand on analysis of improvement strategies (e.g., intervention effectiveness, and quarterly reporting of these analyses). • Widen the strategy to include additional member-specific interventions. • Identify internal processes implemented as interventions (e.g. new programs, practices, or infrastructure, such as new patient registries or data tools.)

PSM

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (PSM)
1. General PIP Information
MCO Name: PSM
PIP Title: PSM Depression Screening Performance Improvement Project
PIP Aim Statement: By CY 2024 we aim to increase the amount of depression screenings for patients between 12 and 17 years in the outpatient level of care by or greater than 3% of PSM baseline (4.1%).
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☒ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): All Medicaid and CHIP between 12 and 17 years of age.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (PSM)

2. Improvement Strategies or Interventions

PSM indicates they are in the "Do" phase of the PDSA cycle; interventions are being outlined to be implemented in the next phases. CY 2022 is stated to be the baseline year, therefore it is not clear what activities, if any occurred in CY 2023 (the period for this review).

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
CMS Child Core Set: CDF-CH Screening for depression and follow-up plan, ages 12–17	CY 2022	442/10,782 (4.10%)	Not Provided	Not Provided	☐ Yes ☒ No	☐ Yes☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not Reported

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☒ First re-measurement ☐ Second re-measurement ☐ Other (specify): Third re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (PSM)
MCO strengths: PSM has a well-organized PIP work plan identifying all phases of design and data collection, key factors for implementing and monitoring improvement plans. PIP Aim Statement was clear and defined the goal, and population impacted. PSM states they are seeking to align with US Preventive Services Task Force (USPSTF) clinical guideline recommendations as well as the Healthy People 2030 recommendation to increase the proportion of adolescents and adults who are screened and receive treatment for depression. **EQRO recommendations:** • Include strategy intended to improve outcomes within the Aim Statement. • Include the data reporting for CY 2023 and utilize the quarterly reporting of outcome data in PDSA process. • Include definition of continuous enrollment. • Clearly identify baseline and re-measurement years. • Include role and qualifications of data collection personnel. • Expand on how measures are calculated from the data warehouse and the process to validate the data. • Include all improvement strategies and/or interventions implemented. • Provide an analysis or interpretation of data outcomes and improvement strategies. • Describe processes to identify gaps in measures for PIP population. • Widen the strategy to include additional evidence-based interventions. • Include Enrollees and/or providers in evaluation of interventions.

Triple-S

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (Triple-S)
1. General PIP Information
MCO Name: Triple-S
PIP Title: Increasing screening for Depression in Primary Care Groups
PIP Aim Statement: The project will impact all active Medicaid population >18 years old capable to answer the questions, in Clinical Management and MBHO Platforms as denominator. Also, MBHO data will be obtained in claims with CPTs: G8431 with positive PHQ-9 and G8510 with negative PHQ-9.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (Triple-S)

Target population description, such as duals, LTSS, or pregnant women (please specify):
Medicaid population >18 years old capable to answer the question in Clinical Management and MBHO Platforms.

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

None Provided

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (Triple-S)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Unique members with screening HCPCS G8510 (Depression Screening follow up is not required)	CY 2023	Numerator/ Denominator not provided Q3 Rate: 13%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Unique members with screening HCPCS G8431 (Depression Screening follow up is required)	CY 2023	Numerator/ Denominator not provided Q3 Rate: 6%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Percentage of PHQ9 in Clinical Performance	CY 2023	Numerator/ Denominator not provided Q3 Rate: 28%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Unique Members HCPCS G8510 or G8431 or Clinical Performance Data	CY 2023	Numerator/ Denominator not provided Q3 Rate: 18%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 2: Increasing Screening for Depression, Anxiety, and/or SUD (Triple-S)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year
☐ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ N/A Baseline Year

MCO strengths:

Triple-S has a well-structured PIP document identifying key factors for implementing and monitoring improvement plans. Triple-S provided a list of goals similar to an aim statement, including improvement goal and time period with general reference to population.

EQRO recommendations:

- Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation.
- Expand definition of population beyond "Medicaid population >18 years old capable to answer the questions" and define "capable".
- Identify Aim Statements in PIP as the Aim Statement and include improvement strategy, following CMS EQR Protocol Guidance for Developing PIP Aim Statements.
- Develop a data collection plan and data analysis plan, clearly defining the method for collecting data, frequency of data collection, data sources, data elements, and data collection instruments for every PIP.
- Provide all outcome data for each metric in the PIP.
- Describe processes to identify gaps in measures for PIP population.
- Include an improvement strategy with PIP development, indicating actions the MCO plans to implement to improve outcomes.
- Provide an analysis or interpretation of data outcomes and improvement strategies.
- Include Enrollees and/or providers in evaluation of interventions.
- Include role and qualifications of data collection personnel.

Topic 3: Improving Outcomes for Enrollees with Diabetes

FMHP

Topic 3: Improving Outcomes for Enrollees with Diabetes (FMHP)
1. General PIP Information
MCO Name: FMHP
PIP Title: Improving of Health Results in Diabetic Members: A Comprehensive Diabetes Care Project
PIP Aim Statement: Achieve an improvement (any) in HEDIS Comprehensive Diabetes Care Measure rates, in diabetic population (diabetes type 1 or 2) or 18 to 85 years for 2024 and 2025 using as a baseline the 2023 results of the measures identified for this PIP. For measures that have PHRIA baseline, the compliance with the baseline or any improvement from this baseline.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Members of 18–85 years diagnosed with diabetes type 1 or 2.
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
2. Improvement Strategies or Interventions
• Identify Enrollees with diabetes diagnosis and abnormal laboratories for HgA1c • Education approach to patients • Mailing education material to targeted Enrollees • Phone calls for patient coaching • Encourage preventive medical evaluations with PCP and specialists according to the beneficiaries needs • Mailing education material to targeted providers • Monitor program activity and outcomes based on achievement thresholds • Revision or development of PIP reports to provide updates on the PIPs interventions/results

Topic 3: Improving Outcomes for Enrollees with Diabetes (FMHP)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Eye Exam for Patients with Diabetes (EED). NCQA – HEDIS	CY 2023	Numerator/ Denominator not provided Rate: 26.17%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Hemoglobin A1c Control for Patients with Diabetes (HBD) (Poor Control) NCQA-HEDIS/CMS Adult Core Set	CY 2023	Numerator/ Denominator not provided Rate: 84.43%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Kidney Health Evaluation Rate for members 18–85 years of age with diabetes who received both an estimated glomerular filtration rate (eGFR) and urine albumin-creatinine (uACR) during the measurement year (KED) NCQA-H	CY 2023	Numerator/ Denominator not provided Rate: 12.05%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
PQI: 01 Diabetes Short-Term Complications Admission Rate AHRQ	CY 2023	Numerator/ Denominator not provided Rate: 71	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 3: Improving Outcomes for Enrollees with Diabetes (FMHP)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
HbA1c tests performed by members that are target for this PIP	CY 2023	Numerator/ Denominator not provided Rate: 77.68%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
ER visit rates for members that are target for this PIP (members of 18-85 years with diabetes type 1 or2)	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Hospital Admissions & Readmissions for members 18-85 years with diabetes type 1 or 2	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Education material sent related to Population target of this PIP (members of 18-85 years with diabetes type 1 or 2)	CY 2023	Data for this metric not provided	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 3: Improving Outcomes for Enrollees with Diabetes (FMHP)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year

☐ First re-measurement ☐ Second re-measurement ☐ Other (specify): Sixth re-measurement

Topic 3: Improving Outcomes for Enrollees with Diabetes (FMHP)

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ NA: Baseline year

MCO strengths:

The FMHP PIP included a clear Aim Statement outlining evaluation rates to be measured, with the population and evaluation time period defined. The PIP program document provides a comprehensive background describing the necessity for the PIP and clearly defines the objectives. FMHP used nationally recognized measures to ensure consistent data collection procedures and included Enrollees and providers in monitoring and result discussions at Quality Advisory Board meetings.

EQRO recommendations:

- Include strategy intended to improve outcomes within the PIP Aim Statement.
- Develop of a comprehensive work plan detailing all requirements and phases and methodology for PIP development, implementation, and evaluation, as well as all activities associated with the PIP.
- Develop comprehensive data collection plan for each metric, including process to collect data, identifying sources and technical specifications, as well as incorporation of analysis for statistical significance in reported data for each metric.
- Provide all data when reporting (e.g., rate and numerator/denominator).
- Provide process for selecting improvement strategy, including explanation how strategy will likely lead to improvement.
- Develop data analysis plan, outlining continuous quality improvement processes and expected cadence. Include description of processes to evaluate interventions, gaps in measures, and actions taken based on evaluation.
- Consider inclusion of Enrollee satisfaction and/or experience of care as a result of PIP activities.
- Consider inclusion of culturally or linguistically appropriate strategies for the PIP population.
- Outline personnel and qualifications for data collection.

MMM

Topic 3: Improving Outcomes for Enrollees with Diabetes (MMM)

1. General PIP Information

MCO Name: MMM

PIP Title: Improving Outcomes Among Members with Diabetes Type 1 Or Type 2

PIP Aim Statement: Will interventions focused on mental health screening and healthy lifestyle, improve the A1c and BP among female beneficiaries with diabetes, over a three-year period?

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):
☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):
☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
Women 45–64 years of age with diagnosis of diabetes type 1 or 2

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Targeted educational activities by Wellness staff focusing on nutrition, weight management, cholesterol, exercise, etc.
- Meet with PM administrative staff to develop a referral process to the collocated provider
- Implement PHQ-9 Screening Process at PMG level
- Educated providers about Standards of Medical Care in Diabetes 2022
- Generate and disseminate provider-specific reports on diabetes measures
- Raise awareness of the improvement project aim and progress with AB participants
- Meet with physicians to give feedback on measure reports

Topic 3: Improving Outcomes for Enrollees with Diabetes (MMM)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
NCQA HEDIS: Blood Pressure Control <140/90 mmHg (BPD)	CY 2022	3,698/9,411 (39.29%)	CY 2023 Q3 (10/01/2022–09/30/2023)	4,023/9,147 (43.98%)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.13666
NCQA HEDIS: HbA1c Poor Control >9% (HBD)	CY 2022	7,217/9,411 (76.67%)	CY 2023 Q3 (10/01/2022–09/30/2023)	6,849/9,147 (74.88%) LOWER IS BETTER	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): 0.06108

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☒ First re-measurement ☐ Second re-measurement ☐ Other (specify): Sixth re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MMM provided evidence of improvement for the metrics in the first year of this PIP. However, the P-value results identified the change in performance was not statistically significant.

MCO strengths:

MMM provided a well-developed PIP including all phases of design and data collection. The PIP Aim Statement clearly identified the strategy, population, and time period. Analysis and Interpretation of PIP results were included. MMM also utilized a driver diagram within their continuous quality improvement approach, outlining the aim, primary drivers and interventions within their PIP.

EQRO recommendations:

- Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation.
- Include methods for soliciting input from providers and/or members.

Topic 3: Improving Outcomes for Enrollees with Diabetes (MMM)
• Expand on the use of technical specifications within the system and processes to ensure stratification approaches are sound and that most recent specifications are used on a regular cadence. • Identify processes in place to identify gaps in measures when needed. • Expand on analysis of improvement strategies (e.g., intervention effectiveness, and quarterly reporting of these analyses). • Widen the strategy to include additional Member specific interventions. • Identify internal processes implemented as interventions (e.g. new programs, practices, or infrastructure, such as new patient registries or data tools).

PSM

Topic 3: Improving Outcomes for Enrollees with Diabetes (PSM)
1. General PIP Information
MCO Name: PSM
PIP Title: Improving Hemoglobin A1c Results in Patient with Diabetes
PIP Aim Statement: Decrease the annual rate of the A1c poor control (>9%) measure for Diabetics by 3% of PSM 2022 benchmark by the end of Contract Year (CY) 2024.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): Medicaid eligible members 18–75 years of age with diabetes (types 1 and 2)
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
2. Improvement Strategies or Interventions
• Member outreach: educational phone interventions, social media posts and videos, educational text messages • Health talks and educational info booths in PMG offices and community outreach • Send list of members without screening • Development of gaps in care report

Topic 3: Improving Outcomes for Enrollees with Diabetes (PSM)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
CMS Adult Core Set/NCQA HEDIS measure: Hemoglobin A1c Control for Patients with Diabetes (HDB) Good Control	CY 2022	2,617/12,274 (21.3%)	Not Provided	Not Provided	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not Reported
CMS Adult Core Set/NCQA HEDIS measure: Hemoglobin A1c Control for Patients with Diabetes (HDB) Poor Control	CY 2022	9,238/12,274 (75.3%) LOWER IS BETTER	Not Provided	Not Provided	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not Reported

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First re-measurement ☐ Second re-measurement ☐ Other (specify): Sixth re-measurement

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Topic 3: Improving Outcomes for Enrollees with Diabetes (PSM)
MCO strengths: PSM has a well-organized PIP work plan identifying all phases of design and data collection, key factors for implementing and monitoring improvement plans. PIP Aim Statement was clear and defined the goal, population impacted and time period for evaluation. **EQRO recommendations:** • Include strategy intended to improve outcomes within the PIP Aim Statement. • Include the data reporting for CY 2023 and utilize the quarterly reporting of outcome data in PDSA process. • Include definition of continuous enrollment. • Include role and qualifications of data collection personnel. For example, is the QA director, tasked with evaluating outcomes, also the individual who is responsible for validating the HEDIS vendor reporting (i.e., using the Data Validation Process P&P), and what are the qualifications of the individual? • Describe processes to identify gaps in measures for PIP population as well as process to validate information obtained from HEDIS vendor. • Include all improvement strategies and/or interventions implemented. • Provide an analysis or interpretation of data outcomes and improvement strategies. • Describe processes to identify gaps in measures for PIP population. • Widen the strategy to include additional evidence-based interventions. • Include enrollees and/or providers in evaluation of interventions.

Triple-S

Topic 3: Improving Outcomes for Enrollees with Diabetes (Triple-S)
1. General PIP Information
MCO Name: Triple-S
PIP Title: Yo Controlo Mi Diabetes Program
PIP Aim Statement: Any improvement of participants A1c level. Any improvement in participants lowering their weight. Achieve 80% of the participants demonstrate knowledge increase for the management and control of their condition. Achieve 70% members retention of at least participation on at least more than half the total interventions of the program.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).

Topic 3: Improving Outcomes for Enrollees with Diabetes (Triple-S)
Target age group (check one): ☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**:
Target population description, such as duals, LTSS, or pregnant women (please specify): All population with a diagnosis of DM that have their A1c levels uncontrolled from Medicaid interested in participating in the program.
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Monthly evaluation of the database to identify affiliates that qualify to participate in the program
- Invite affiliates by regular mail to participate in the program
- Phone calls to affiliates to invite them to participate in the program and check the hours availability to attend the program
- Promote the program in the PMGs and social networks
- Transportation coordination according to the plan coverage or with community agencies
- Educational Campaign about the importance of the re certification process to comply with the requirements to maintenance the health insurance
- Complete call blast to the target population of this program about the importance of testing A1C and keeping it under control
- Send educational material to all affiliates about the A1C test and keep it under control
- Develop weekly face-to-face educational intervention and offer pre- and post-test
- In each Yo Controlo Mi Diabetes program, two screening clinics will be held to measure blood glucose levels. One will be conducted at the beginning of the program and one at the end of the program

Topic 3: Improving Outcomes for Enrollees with Diabetes (Triple-S)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable)	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Reduce or maintain in control the A1C levels in participants (<9).	CY 2023	Not Provided	CY 2023 Q4	100% (3/3)	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Achieve 80% of the participants demonstrate knowledge increase for the management and control of their condition.	CY 2023	Not Provided	CY 2023 Q4	100% (3/3)	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Achieve 89% of the participants demonstrate knowledge increase for the management and control of their condition.	CY 2023	Not Provided	CY 2023 Q4	67% (2/3)	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year
☐ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ N/A Baseline Year

Topic 3: Improving Outcomes for Enrollees with Diabetes (Triple-S)
MCO strengths: Triple-S has a well-structured PIP document identifying key factors for implementing and monitoring improvement plans. Triple-S provided a list of goals similar to an Aim Statement, including improvement goal and time period with general reference to population. **EQRO recommendations:** • Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation. • Clearly define metrics, as it was unclear if Triple-S used the HEDIS measure, Comprehensive Diabetes Care: HbA1c Poor Control (<9.0%), as required by the contract. • Expand definition of population, including age, diagnoses, continuous enrollment requirements, and criteria for “uncontrolled”. • Identify Aim Statements in PIP as the Aim Statement and include improvement strategy, following CMS EQR Protocol guidance for developing PIP Aim Statements. • Develop a data collection plan and data analysis plan, clearly defining baseline year, the method for collecting data, frequency of data collection, data sources, data elements, and data collection instruments for every PIP. • Provide all outcome data for each metric in the PIP. • Describe processes to identify gaps in measures for PIP population. • Include continuous quality improvement (e.g., PDSA) activities to test the strategy and observe data collection accuracies. • Provide an analysis or interpretation of data outcomes and improvement strategies. • Include enrollees and/or providers in evaluation of interventions. • Include role and qualifications of data collection personnel.

Topic 4: Improving EPSDT Screening Rates

FMHP

Topic 4: Improving EPSDT Screening Rates (FMHP)
1. General PIP Information
MCO Name: FMHP
PIP Title: Early, Periodic, Screening, Diagnosis and Treatment Program
PIP Aim Statement: Achieve an improvement (any) in the CMS 416 Participation Ratio and Screening Ratio for 2024 and 2025 using as a baseline the 2023 results of the CMS 416 for FMHP population of 0 to 21 years. For Well-Child Visit measures (0–15 months and 15–30 months) and Child and Adolescent Well-Care (3–21 years) visits that have PHRIA baseline for 2023, achieve compliance with the PHRIA baseline or any improvement from this baseline in 2023, 2024, and 2025.

Topic 4: Improving EPSDT Screening Rates (FMHP)
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State.). ☐ Plan choice (State allowed the plan to identify the PIP topic).
Target age group (check one): ☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children ☐ Other: Target age group not identified ***If PIP uses different age threshold for children, specify age range here**: 0–21 years of age
Target population description, such as duals, LTSS, or pregnant women (please specify): Members age 0–21years
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
2. Improvement Strategies or Interventions
• Establish collaborative initiatives with Schools of Public Health, Community Health Centers, Medicaid Program, DOH - Vaccines for Children Program, Coalicion de Vacunacion de PR, Professional Organizations as the Academy of Family Medicien and The American academy of Pediatrics – PR Chapter • Establish community outreach awareness and in mass campaigns of promotion, preventions and protection in public health initiatives • Mailing education material to targeted providers • Specific training of EPSDT provided to contracted providers • Share reports with PMGs to establish strategies to comply with the measure's benchmarks and PIP goals • Monitor program activity and outcomes based on achievement thresholds • Revision or development of PIP reports to provide updates on the PIPs interventions/results

Topic 4: Improving EPSDT Screening Rates (FMHP)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Well-Child Visit for First 30 Months of Life: Ages 0–15 months. NCQA – HEDIS	CY 2023	Numerator/ Denominator not provided Rate: 4.03%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Well-Child Visit for First 30 Months of Life: Ages 15-–30 months. NCQA – HEDIS	CY 2023	Numerator/ Denominator not provided Rate: 23.55	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Child and Adolescent Well-Care Visits (WCV). NCQA – HEDIS	CY 2023	Numerator/ Denominator not provided Rate: 31.44%	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
CMS 416 Screening Ratio	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
CMS 416 Participation Ratio	CY 2023	Numerator/ Denominator and rate not provided, "in determination process"	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 4: Improving EPSDT Screening Rates (FMHP)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year
☐ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ NA: Baseline year

MCO strengths:

The FMHP PIP included a clear Aim Statement outlining evaluation rates to be measured, with the population and evaluation time period defined. The PIP program document provides a comprehensive background describing the necessity for the PIP and clearly defines the objectives. FMHP used nationally recognized measures to ensure consistent data collection procedures and included Enrollees and providers in monitoring and result discussions at Quality Advisory Board meetings.

EQRO recommendations:

- Include strategy intended to improve outcomes within the PIP Aim Statement.
- Develop of a comprehensive work plan detailing all requirements and phases and methodology for PIP development, implementation, and evaluation, as well as all activities associated with the PIP.
- Develop comprehensive data collection plan for each metric, including process to collect data, identifying sources and technical specifications, as well as incorporation of analysis for statistical significance in reported data for each metric.
- Provide all data when reporting (e.g., rate and numerator/denominator).
- Provide process for selecting improvement strategy, including explanation how strategy will likely lead to improvement.
- Develop data analysis plan, outlining continuous quality improvement processes and expected cadence. Include description of processes to evaluate interventions, gaps in measures, and actions taken based on evaluation.
- Consider inclusion of Enrollee satisfaction and/or experience of care as a result of PIP activities.
- Consider inclusion of culturally or linguistically appropriate strategies for the PIP population.
- Outline personnel and qualifications for data collection.

MMM

Topic 4: Improving EPSDT Screening Rates (MMM)

1. General PIP Information

MCO Name: MMM

PIP Title: EPSDT Performance Improvement Project

PIP Aim Statement: Will the use of educational material and targeted interventions of face-to-face meetings and workshops improve well child visit rates among girls from 3 to 8 years of age, over a three-year period?

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):
☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State.).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):
☒ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children
☐ Other: Target age group not identified
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
Females ages 3–8 years

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Reconcile reports based on study population
- Targeted presentation for providers
- Quality workshops with PMGs to work and provide guide with reports
- Targeted reports to discuss in PPEs (PPE is not spelled out)
- Educational Material for providers (email and bulletins)
- Coordination with Wellness staff for educational campaign

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
NCQA HEDIS/CMS Child Core Set: Child and Adolescent Well-Care Visit (WCV). Stratified by female gender, ages 3-8 years	CY 2022	6,213/11,580 (53.65%)	CY 2023 Q3 (10/01/2022–09/30/2023)	6794/11021 (61.65%)	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

Topic 4: Improving EPSDT Screening Rates (MMM)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☒ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

MCO strengths:

MMM provided a well-developed PIP including all phases of design and data collection. The PIP Aim Statement clearly identified the strategy, population, and time period. Analysis and Interpretation of PIP results were included.

EQRO recommendations:

- Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation.
- Include methods for soliciting input from providers and/or members.
- Expand on the use of technical specifications within the system and processes to ensure stratification approaches are sound and that most recent specifications are used on a regular cadence.
- Identify processes in place to identify gaps in measures when needed.
- Expand on analysis of improvement strategies (e.g., intervention effectiveness, and quarterly reporting of these analyses).
- Widen the strategy to include member-specific interventions.

PSM

Topic 4: Improving EPSDT Screening Rates (PSM)

1. General PIP Information

MCO Name: PSM

PIP Title: PSM EPSDT Performance Improvement Project

PIP Aim Statement: Increase the annual rate of Well Child Care Visit (W30) to perform at or above 3% of PSM 2022 benchmark by Contract Year (CY) 2024.

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):

☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):

☒ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children
☐ Other: Target age group not identified

***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):

Children who turned 15 months old during the measurement year.

Children who turned 30 months old during the measurement year.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Care Managers provide outreach interventions to families about the importance of well child visits through the EPSDT program, including calls and letters
- Providers receive on a quarterly basis a file that includes a list of non-compliant members
- Care Managers provided education to providers about the well child visits
- Development of gaps in care report

Topic 4: Improving EPSDT Screening Rates (PSM)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
CMS Core Set/NCQA HEDIS: Well-Child Visits in the First 15 Months (W30)	CY 2022	205/1,974 (10.39%)	Not Reported	Not Reported	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not Reported
CMS Core Set/NCQA HEDIS: Well-Child Visits for Age 15 Months–30 Months (W30)	CY 2022	820/2,043 (40.14%)	Not Reported	Not Reported	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not Reported

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Topic 4: Improving EPSDT Screening Rates (PSM)
MCO strengths: PSM has a well-organized PIP work plan identifying all phases of design and data collection, key factors for implementing and monitoring improvement plans. PIP Aim Statement was clear and defined the goal, population impacted and time period for evaluation. **EQRO recommendations:** • Include strategy intended to improve outcomes within the PIP Aim Statement. • Include the data reporting for CY 2023 and utilize the quarterly reporting of outcome data in PDSA process. • Include definition of continuous enrollment. • Include role and qualifications of data collection personnel. For example, is the QA director, tasked with evaluating outcomes, also the individual who is responsible for validating the HEDIS vendor reporting (i.e., using the Data Validation Process P&P), and what are the qualifications of the individual? • Describe processes to identify gaps in measures for PIP population as well as process to validate information obtained from HEDIS vendor. • Include all improvement strategies and/or interventions implemented. • Provide an analysis or interpretation of data outcomes and improvement strategies. • Describe processes to identify gaps in measures for PIP population. • Widen the strategy to include additional evidence-based interventions. • Include Enrollees and/or providers in evaluation of interventions.

Triple-S

Topic 4: Improving EPSDT Screening Rates (Triple-S)
1. General PIP Information
MCO Name: Triple-S
PIP Title: EPSDT Dental Visit
PIP Aim Statement: Any annual improvement in the Triple-S, Dental Visit benchmark percentage of Well Child Visits for the entire pediatric population in the 5- to 7-year-old category. Reach 50% of the total pediatric population aged 5–7 years included in the study. To recruit 30% of the total selected population that has not attended the dentist for their annual check-up. 100% completion of Pediatric HRA to eligible members.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic) ☐ Collaborative (plans worked together during the planning or implementation phases) ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State) ☐ Plan choice (State allowed the plan to identify the PIP topic)

Topic 4: Improving EPSDT Screening Rates (Triple-S)

Target age group (check one):
☒ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☐ Both adults and children
☐ Other: Target age group not identified
***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
All children between 5 and 7 years of age who have not had their dental checkup one year ago to date.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Reinforce education efforts directed to the Dental Health Project population on the importance of dental visits once a year and oral cleaning follow-ups every six months through phone calls made by the Coordinated Care sub-unit
- Encourage and assist parents to schedule a visit with the dentist
- Call blaster initiative for the entire EPSDT population (5–7 years) where parents are oriented about the importance of dental health visit.
- Strengthen provider education on EPSDT preventive visits and Dental Care
- Barrier's identification through outreach that is performed at the time of providing orientations for immediate interventions
- Call audits will be performed as well as the entry of notes in the corporate tool as any documentation format
- On-going monitoring of the Dental Health PIP Dashboard, which incorporates the claims received and outreach performed

Topic 4: Improving EPSDT Screening Rates (Triple-S)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Any Improvement in Dental Visit benchmark percentage of Well Child Visits for the entire pediatric population in the 5 to 7 year old category.	April 1, 2023–March 31, 2024 (CY 2023 Q4 data)	55% (6,080/11,144)	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Reach 50% of the total pediatric population aged 5–7 years included in the study.	April 1, 2023–March 31, 2024 (CY 2023 Q4 data)	Data provided was inaccurately reported.	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Recruit 30% of the total selected population that has not attended the dentist for their annual check-up.	April 1, 2023–March 31, 2024 (CY 2023 Q4 data)	54% (5,995/11,144)	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
100% completion of Pediatric HRA to eligible members.	April 1, 2023–March 31, 2024 (CY 2023 Q4 data)	21% (2,385/11,144)	NA: Baseline CY 2023	NA: Baseline CY 2023	☐ Yes ☐ No	☐ Yes ☐ No ☒ NA: Baseline CY 2023 Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

Topic 4: Improving EPSDT Screening Rates (Triple-S)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☒ Baseline year
☐ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence ☒ N/A Baseline Year

MCO strengths:

Triple-S has a well-structured PIP document identifying key factors for implementing and monitoring improvement plans. Triple-S provided a list of goals similar to an Aim Statement, including improvement goal and time period with general reference to population.

EQRO recommendations:

- Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation.
- Clearly define metrics, and population impacted, as it was not clear if the PIP was focused on 5–7 year-old Enrollees or the entire EPSDT population.
- Identify Aim Statements in PIP as the Aim Statement and include improvement strategy, following CMS EQR Protocol guidance for developing PIP Aim Statements.
- Develop a data collection plan and data analysis plan, clearly defining baseline year, the method for collecting data, frequency of data collection, data sources, data elements, and data collection instruments for every PIP.
- Provide all outcome data for each metric in the PIP.
- Validate all outcome data in the PIP.
- Describe processes to identify gaps in measures for PIP population
- Include continuous quality improvement (e.g., PDSA) activities to test the strategy and observe data collection accuracies.
- Provide an analysis or interpretation of data outcomes and improvement strategies.
- Include enrollees and/or providers in evaluation of interventions.
- Include role and qualifications of data collection personnel.

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health

FMHP

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (FMHP)

1. General PIP Information

MCO Name: FMHP

PIP Title: Improve Communication with BH Providers with PCP in Co-location. Diabetes screening for people with Schizophrenia or bipolar disorder who are using antipsychotic medications (SSD).

PIP Aim Statement: By December 31, 2023, we aim to increase the percentage of case discussions between the PCP and BH providers of initial patients that receive services in the primary groups by 3% of 27% (2022 result) during the year. We aim to increase the amount of diabetes screenings for people with Schizophrenia or bipolar disorder who are using antipsychotic medications (SSD). Such an increase would be greater than the year's baseline (2023) and will be measured as of December 31, 2024.

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):

☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):

☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children
☐ Other: Target age group not identified

***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):

Initial patient for collocated behavioral providers that receives services in the PMG.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Requesting input from patients through evaluation and screening
- Tailoring communication to individual patient needs
- Providing discharge summaries for transitioning patients
- Enhancing communication between PCPs and BH providers
- Advocating for integrated care
- Utilizing standardized documentation and integrated EMR systems

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (FMHP)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Improve Communication with BH Providers with PCP in Co-location	CY 2022	27.1 % (1,680/6,193)	Not Identified	35% (1,701/4,866)	☒ Yes ☐ No ☐ NA	☐ Yes ☒ No ☐ NA Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance
Diabetes Screening for people with Schizophrenia or bipolar disorder who are using antipsychotic medications (SSD). HEDIS-NCQA	CY 2022	Numerator/ Denominator not provided Rate: 54%	Not Provided/ Baseline 2023?	Not Provided	☐ Yes ☒ No ☐ NA	☐ Yes ☒ No ☐ NA Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Data reported did not consistently articulate baseline year for one of the measures or include repeated measurements and remeasurement period to verify if there is consistent improvement. Evaluation for statistically significant improvement was not performed/reported.

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (FMHP)

MCO strengths:

FMHP revised PIP Aim Statements to include evaluation rates to be measured, with the population and evaluation time period defined. The PIP program document provides a comprehensive background describing the necessity for the PIP and clearly defines the objectives. FMHP included a nationally recognized measure and included Enrollees and providers in monitoring and result discussions at Quality Advisory Board meetings.

EQRO recommendations:

- Develop one comprehensive Aim Statement for the PIP.
- Work with FMHP's BH vendor to develop of a comprehensive work plan detailing all requirements, phases and methodology for PIP development, implementation, and evaluation, as well as all activities associated with the PIP.
- Develop comprehensive data collection plan for each metric, including process to collect data, identifying sources and technical specifications, as well as incorporation of analysis for statistical significance in reported data for each metric.
- Provide all data when reporting (e.g., rate and numerator/denominator).
- Describe process to evaluate availability of data with existing measures (e.g., measures reported as in determination process) within the workplan.
- Provide process for selecting improvement strategy, including explanation how strategy will likely lead to improvement.
- Clearly describe interventions implemented (e.g., how FMHP enhanced communication between PCPs and BH providers and advocated for integrated care).
- Develop data analysis plan, outlining continuous quality improvement processes and expected cadence. Include description of processes to evaluate interventions, gaps in measures, and actions taken based on evaluation.
- Consider inclusion of Enrollee satisfaction and/or experience of care as a result of PIP activities.
- Consider inclusion of culturally or linguistically appropriate strategies for the PIP population.
- Outline personnel and qualifications for data collection.

MMM

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (MMM)

1. General PIP Information

MCO Name: MMM

PIP Title: Performance Improvement Project to Increase Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health

PIP Aim Statement: Will the periodic workshops meetings with PMGs and Mental Health Clinics, decrease the emergency visits among beneficiaries with a co-occurring physical health condition and substance use disorders who may benefit from Integrated physical and behavioral health care over a three-year period?

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):

☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):

☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children
☐ Other: Target age group not identified

***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
Beneficiaries, 18 years of age and older, with co-occurring physical health and mental health conditions.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Quality Workshops with PMGs – Meet with PMG administrative staff to develop a referral process to the collocated provider and implement PHQ-9 Screening Process
- Quality Workshops with MH Clinics Meetings coordinated by the MH Department, with the MH Clinics administration and participation of the Clinical Quality Program Manager
- Face-to-face visits by Clinical Auditors to assigned PCPs to promote utilization of collocated providers

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (MMM)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
CMS IAP (PMH-20) Measure: Number of all-cause emergency department visits that do not result in an inpatient admission or observation stay per 1,000 member months for Medicaid beneficiaries age 18 and older who meet he eligibility criteria for Beneficiaries with co-occurring physical health and mental health conditions (PH=MH)	CY 2022	5,504/122,824 (44.81/1,000 member months)	CY 2023 Q3 (10/01/2022–09/30/2023)	5,637/129,523 (43.52/1,000 member months) LOWER IS BETTER	☒ Yes ☐ No	☒ Yes ☐ No Specify P-value: ☒ <.01 ☐ <.05 Other (specify):

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (MMM)
Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results. ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence **Validation rating # 2:** EQRO's overall confidence that the PIP produced significant evidence of improvement. ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
MCO strengths: MMM provided a well-developed PIP including all phases of design and data collection. The PIP Aim Statement clearly identified the strategy, population, and time period. Analysis and Interpretation of PIP results were included. **EQRO recommendations:** • Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation. • Include methods for soliciting input from providers and/or members. • Expand on the use of technical specifications within the system and processes. • Identify processes in place to identify gaps in measures when needed. • Expand on analysis of improvement strategies (e.g., intervention effectiveness, and quarterly reporting of these analyses). • Widen the strategy to include Member specific interventions. • Identify internal processes implemented as interventions (e.g. new programs, practices, or infrastructure, such as new patient registries or data tools).

PSM

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (PSM)
1. General PIP Information
MCO Name: PSM
PIP Title: Improve Communication with Behavioral Health Providers with PCP in Co-location
PIP Aim Statement: PSM aims to increase the number of case discussions between the PCP and behavioral health providers during the year. The increase should be greater than 3% of the 2023 results (28%) and will be measured as of December 31,2024.
Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply): ☒ State-mandated (State required plans to conduct a PIP on this specific topic). ☐ Collaborative (plans worked together during the planning or implementation phases). ☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State). ☐ Plan choice (State allowed the plan to identify the PIP topic).

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (PSM)

Target age group (check one):
☐ Children only (ages 0–17 years)* ☐ Adults only (age 18 years and over) ☒ Both adults and children
☐ Other: Target age group not identified

***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):
Initial patient for collocated behavioral services that receives services in the PMG.

Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Solicit input from patients through evaluation and screening
- Tailoring communication to individual patient needs
- Providing discharge summaries for transitioning patients
- Enhancing communication between PCPs and BHPs
- Advocating for integrated care
- Utilizing standardized documentation and integrated EMR systems

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (PSM)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Improve Communication with BH Providers with PCP in Co-location	CY 2018	13% (Numerator/ Denominator not provided)	CY 2022 CY 2023 reported as pending	1,048/3,431 (30.5%)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): Not Reported

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (PSM)

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No
"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):
☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year
☐ First re-measurement ☐ Second re-measurement ☒ Other (specify): Fifth remeasurement year

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (PSM)

4. PIP Validation Information

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

MCO strengths:

PSM has a well-organized PIP work plan identifying all phases of design and data collection, key factors for implementing and monitoring improvement plans. PIP Aim Statement was clear and defined the goal, population impacted and time period for evaluation.

EQRO recommendations:

- Include strategy intended to improve outcomes within the PIP Aim Statement.
- Include the data reporting for CY 2023 and utilize the quarterly reporting of outcome data in PDSA process.
- Include definition of continuous enrollment.
- Include role and qualifications of data collection personnel.
- Expand on how measures are calculated from the data warehouse and the process to validate the data.
- Describe processes to identify gaps in measures for PIP population.
- Include all improvement strategies and/or interventions implemented.
- Provide an analysis or interpretation of data outcomes and improvement strategies.
- Widen the strategy to include additional evidence-based interventions.
- Provide clear descriptions of activities implemented (e.g., how communication between PCP and BH providers were enhanced).
- Include Enrollees and/or providers in evaluation of interventions.

Triple-S

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (Triple-S)

1. General PIP Information

MCO Name: Triple-S

PIP Title: Improve the Communication between Behavioral Health Providers and Primary Care Physicians (PCP) in Co-location

PIP Aim Statement: We aim to increase the number of case discussions between the PCP and behavioral health providers during the year. The increase should be greater than 2% of the 2023 results and will be measured as of December 31,2024.

Was the PIP State-mandated, collaborative, Statewide, or plan choice? (check all that apply):

☒ State-mandated (State required plans to conduct a PIP on this specific topic).
☐ Collaborative (plans worked together during the planning or implementation phases).
☐ Statewide (the PIP was conducted by all MCOs and/or PIHPs within the State).
☐ Plan choice (State allowed the plan to identify the PIP topic).

Target age group (check one):

☐ Children only (ages 0–17 years)* ☒ Adults only (age 18 years and over) ☐ Both adults and children
☐ Other: Target age group not identified

***If PIP uses different age threshold for children, specify age range here**:

Target population description, such as duals, LTSS, or pregnant women (please specify):

Members Eligible population who receives and initial Co-location services in a Primary Care Group, that have at least a clinical case discussion or referral with the PCP and the BH professional in the co-location setting.

Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions

- Meeting with the Primary Medical Groups and established different strategies to impact case discussion
- Re-orientation of PCP's, sharing PCP contact lists to collocated, establishment of case discussion meetings within collocated and PMG clinical staff
- Educational reinforce to the PMG for a multidisciplinary approach to case discussion. Educational flyer established within Triple-S

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (Triple-S)

3. PMs and Results

PMs (be specific and indicate measure steward and NQF number if applicable):	Baseline year	Baseline sample size and rate	Most recent re-measurement year (if applicable)	Most recent re-measurement sample size and rate (if applicable)	Demonstrated performance improvement (Yes/No)	Statistically significant change in performance (Yes/No) Specify P-value
Increase number of case discussions between the PCP and behavioral health providers during the year.	CY 2022	37.5%	CY 2023	37.7%	☒ Yes ☐ No	☐ Yes ☐ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): ☒ Not analyzed for statistical significance

4. PIP Validation Information

Was the PIP validated? ☒ Yes ☐ No

"Validated" means that the EQRO reviewed all relevant part of each PIP and made a determination as to its validity. In many cases, this will involve calculating a score for each relevant stage of the PIP and providing feedback and recommendations.

Validation phase (check all that apply):

☐ PIP submitted for approval ☐ Planning phase ☐ Implementation phase ☐ Baseline year

☒ First re-measurement ☐ Second re-measurement ☐ Other (specify):

Validation rating # 1: EQRO's overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis and interpretation of PIP results.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Validation rating # 2: EQRO's overall confidence that the PIP produced significant evidence of improvement.

☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence

Data provided was inconsistently reported. During the virtual on-site review, Triple-S reported the data provided was not accurate and resubmitted the correct data.

MCO strengths:

Triple-S has a well-structured PIP document identifying key factors for implementing and monitoring improvement plans. Triple-S provided a list of goals similar to an Aim Statement, including improvement goal and time period with general reference to population.

EQRO recommendations:

- Provide complete and comprehensive responses to PIP RFI questions to ensure all information is available for PIP evaluation.
- Identify Aim statements in PIP as the Aim Statement and include improvement strategy, following CMS EQR Protocol Guidance for Developing PIP Aim Statements.
- Develop a data collection plan and data analysis plan, clearly defining baseline year, the method for collecting data, frequency of data collection, data sources, data elements, and data collection instruments for every PIP.

Topic 5: Increasing Use of Reverse Co-Location and Co-Location of Physical and Behavioral Health (Triple-S)
• Validate all outcome data in the PIP, performing quality monitoring of all reported data. • Describe processes to identify gaps in measures for PIP population. • Include continuous quality improvement (e.g., PDSA) activities to test the strategy and observe data collection accuracies. • Provide an analysis or interpretation of data outcomes and improvement strategies. • Include Enrollees and/or providers in evaluation of interventions. • Include role and qualifications of data collection personnel. • Define improvement strategy/actions the MCO plans to implement to improve outcomes.

Section 4

Validation of Performance Measures

Introduction

The PM Validation process assesses the accuracy of PMs reported by the MCO in accordance with 42 CFR § 438.358(b)(ii) and to determine the extent to which the MCO follows state specifications and reporting requirements. Mercer conducted this activity in accordance with 42 CFR § 438.358(b)(ii) using the analytic approach established in CMS EQR Protocol 2.

Validate the accuracy of Medicaid PMs reported by MCOs.

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of organizational charts, training materials, P&Ps, HEDIS Roadmaps, HEDIS final audit reports, data integration diagrams used for PM extraction, and other supporting documentation and descriptions included in the response to RFI. This review was conducted based on information submitted by the MCOs through the RFI and through virtual meetings held in July 2024. The meetings involved participation from MCOs key leadership including, but not limited to vice presidents (VPs) and directors of business intelligence, analytics, operations, quality, etc.

Review Methodology and Data Collection

Mercer conducted the validation process in accordance with the CMS, EQR Protocol 2: Validation of PMs. The main objectives of PM Validation are to:

- Evaluate the accuracy of PM data collected by the MCO based on the measure specifications.
- Assess data integration and control for PM calculation to determine if the MCO has adequate processes in place to ensure data completeness and data quality.
- Review PM rates production processes to determine the MCO's ability to identify numerator and denominator eligible members accurately.

To accomplish these objectives, Mercer performed the following:

- Pre-Audit Activities — Mercer developed and distributed the RFI to gather information specific to the information systems used to collect the data used for PM rate calculation.
- Data Collection and Analysis — Mercer reviewed the responses submitted in the RFI and supporting documentation, which included the HEDIS Roadmaps and HEDIS Reports.
- Virtual On-Site Activities — Mercer conducted interviews with the MCO staff to discuss the information systems used to collect the data and to review processes used for collecting, storing, validating, and reporting the PM data.

Overall Assessment

The EQRO provides an overall validation rating of the PM results. The validation rating refers to the EQRO's overall confidence that the PM calculation adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, and produced accurate HEDIS rates. Validation ratings are described in the following table.

High confidence	Moderate confidence	Low confidence	No confidence
All required documentation is present, MCO staff provides responses that are consistent with each other and with the documentation, or a state-defined percentage of all data sources (documents or MCO staff) provide evidence of compliance with regulatory or contractual provisions.	After review of the documentation and discussion with MCO staff, it is determined that the MCO has met most of the requirements as required for the Met category.	MCO staff describes and verifies the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.	After review of the documentation and discussion with MCO staff, it is determined that although some requirements have been met, the MCO has not met most of the requirements.

Measures Selected

For this review, Mercer conducted PM validation in accordance with CMS EQR Protocol 2 on six measures that were selected by Puerto Rico. The measures validated are outlined in the table below.

PM
PM 1: Cervical Cancer Screening (CCS-AD)
PM 2: Breast Cancer Screening (BCS-E-AD)
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Comparative Analysis — Overall Assessment Results

The tables that follow contain the results of the validation of the selected measures across the plans. EQRO reviewed numerous documents submitted as part of the RFI and conducted interviews with the MCO key stakeholders to make the determination on the overall assessment.

MCO MY 2023 Confidence Results

PM	FMHP	MMM	PSM	Triple-S
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence	High confidence	High confidence	High confidence
PM 2: Breast Cancer Screening (BCS-E-AD)	Moderate confidence	High confidence	High confidence	High confidence
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	High confidence	High confidence	High confidence	Moderate confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence	High confidence	High confidence	High confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	Moderate confidence	High confidence	High confidence	High confidence
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence	High confidence	High confidence	High confidence

Comparative Analysis — Rates Results

The following tables contain the rates of the selected measures across the plans. EQRO reviewed numerous documents submitted as part of the RFI and conducted interviews with the MCO key stakeholders to make the determination on the overall assessment.

MCO MY 2023 Rates Results

PM	FMHP	MMM	PSM	Triple-S
PM 1: CCS-AD	43.32%	48.99%	55.24%	50.37%
PM 2: BCS-E-AD				
Rate 1 (50–64)	49.92%	65.91%	NR	NR
Rate 2 (65–74)	40.54%	53.86%	NR	NR
Total	**NR**	**63.62%**	**68.13%**	**64.11%**
PM 3: AMM-AD				
Rate 1 (18–64)	1.78%	NR	58.13%	NR
Rate 2 (65+)	5.88%	NR	60.86%	NR
Total	**NR**	**51.64%**	**58.32%**	**48.87%**
PM 4: CIS-CH Combo 3	0.34%	43.53%	3.79%	4.75%
PM 5: AMR-CH				
Rate 1 (5–11)	NR	97.78%	96.01%	97.14%
Rate 2 (12–18)	NR	92.83%	92.31%	93.79%
Total	**96.40%**	**96.09%**	**NR**	**NR**
PM 6: ADD-CH	NA*	77.78%	60.47%	63.59%

*Reported 0 numerator/ 0 denominator

Comparative Analysis — Plan Results of Selected Measures

FMHP Results

PM	Confidence in Reported Results
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence
PM 2: Breast Cancer Screening (BCS-E-AD)	Moderate confidence
PM 3: Antidepressant Medication Management — Acute Phase (AMM-AD)	High confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	Moderate confidence
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence

Cervical Cancer Screening (CCS-AD)
Cervical Cancer Screening (CCS-AD) Overview
MCO name: FMHP
PM name: Cervical Cancer Screening (CCS-AD)
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____
Is the PM part of an existing measure set? (check all that apply) ☒ HEDIS ☒ CMS Child or Adult Core Set ☐ Other (specify):
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe): Claims data ☐ Medical records (describe): ☐ Other (specify):

Cervical Cancer Screening (CCS-AD)

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling based on HEDIS MY 2023 Specifications

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Women 24–64 years as of December 31 of the measurement year.

Definition of numerator (describe):

The number of women who were screened for cervical cancer.

1. Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the 2 years prior to the measurement year.
2. Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of the test.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Cervical Cancer Screening (CCS-AD) Results

	PM
Numerator	90,408
Denominator	39,161
Rate	43.32%

Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Cervical Cancer Screening (CCS-AD)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-E – AD)

Breast Cancer Screening (BCS-E - AD) Overview

MCO name: FMHP

PM name: Breast Cancer Screening (BCS-E-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling based on HEDIS MY 2023 Specifications

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Women 52–74 years as of December 31 of the measurement year.

Breast Cancer Screening (BCS-E – AD)

Definition of numerator (describe):
Women who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023.

Breast Cancer Screening (BCS-E - AD) Results

PM	Rate 1 (18-64 years)[1]	Rate 2 (65+ years)[2]	Total[3]
Numerator	10,704	2,090	NR
Denominator	21,442	5,156	NR
Rate	49.92%	40.54%	NR

Breast Cancer Screening (BCS-E - AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
FMHP reported there were no deviations from the technical specifications; however, age bands reported by FMHP were not consistent with NCQA technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.
☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: FMHP must calculate the HEDIS rates per NCQA specifications and required stratifications.

[1] FMHP did not submit the numerator, denominator and rate with the correct stratification by age, as required per HEDIS specifications.
[2] FMHP did not submit the numerator, denominator and rate with the correct stratification by age, as required per HEDIS specifications
[3] FMHP did not report total numerator, denominator and rate.

Antidepressant Medication Management — Acute Phase (AMM-AD)

Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

MCO name: FMHP

PM name: Antidepressant Medication Management — Acute Phase (AMM-AD)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
Sampling based on HEDIS MY 2023 Specifications
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Members 18 years and older as of the Index prescription start date (IPSD).

Definition of numerator (describe):
Members with at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023.

Antidepressant Medication Management — Acute Phase (AMM-AD)			
Antidepressant Medication Management — Acute Phase (AMM-AD) Results			
PM	**Acute Phase Rate 1 (18-64 years)**	**Acute Phase Rate 2 (65+ years)**	**Acute Phase Total[4]**
Numerator	5	2	NR
Denominator	210	20	NR
Rate	2.38%	10.00%	NR
Antidepressant Medication Management — Acute Phase (AMM-AD) Validation Status			
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the technical specifications.			
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.			
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)			
Describe any other validation findings that affected the accuracy of the PM calculation. N/A			
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.			
EQRO recommendations for improvement of PM calculation: FMHP must report the HEDIS rates per NCQA specifications and required stratifications as well as totals.			

[4] FMHP did not report total numerator, denominator and rate.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: FMHP

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
Sampling based on HEDIS MY 2023 Specifications
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Children who turn 2 years of age during the measurement year.

Definition of numerator (describe):
Children who received the required doses of DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023.

Childhood Immunization Status Combo 3 (CIS-CH) Results

PM	Combo 3
Numerator	11
Denominator	3,252
Rate	0.34%

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Childhood Immunization Status Combo 3 (CIS-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: FMHP

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Asthma Medication Ratio: 5 to 18 (AMR-CH)
Is the PM part of an existing measure set? (check all that apply) ☒ HEDIS ☒ CMS Child or Adult Core Set ☐ Other (specify):
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe): Claims data ☐ Medical records (describe): ☐ Other (specify):
If the hybrid method was used, describe the sampling approach used to select the medical records: Sampling based on HEDIS MY 2023 Specifications ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): Children ages 5–18 years as of December 31 of the measurement year.
Definition of numerator (describe): The number of members who have a medication ratio of ≥0.50 during the measurement year.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 1, 2023–December 31, 2023.

Asthma Medication Ratio: 5 to 18 (AMR-CH) Results			
PM	**Rate 1 (5-11)[5]**	**Rate 2 (12-18)**	**Total**
Numerator	NR	NR	107
Denominator	NR	NR	111
Rate	NR	NR	96.40%

Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.

[5] FMHP did not submit the numerator, denominator and date with the stratification by age as required per HEDIS specifications.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: FMHP must calculate the HEDIS rates per NCQA specifications and required stratifications.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: FMHP

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling based on HEDIS MY 2023 Specifications

☒ Not applicable (hybrid method not used)

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)
Definition of denominator (describe): Children 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.
Definition of numerator (describe): All children who meet the following criteria: Numerator compliant for Rate 1—Initiation Phase, and At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 1, 2023–December 31, 2023

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results	
PM	**Continuation and Management**
Numerator	0
Denominator	0
Rate	0.00%

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. N/A
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No “Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

MMM Results

PM	Confidence in Reported Results
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence
PM 2: Breast Cancer Screening (BCS-E - AD)	High confidence
PM 3: Antidepressant Medication Management – Acute Phase (AMM-AD)	High confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	High confidence
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence

Cervical Cancer Screening (CCS-AD)

1. Cervical Cancer Screening (CCS-AD) Overview

MCO name: MMM

PM name: Cervical Cancer Screening (CCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling based on HEDIS MY 2023 Specifications

☒ Not applicable (hybrid method not used)

Cervical Cancer Screening (CCS-AD)

1. Cervical Cancer Screening (CCS-AD) Overview

Definition of denominator (describe):
Women 24–64 years as of December 31 of the measurement year.

Definition of numerator (describe):
The number of women who were screened for cervical cancer.

1. Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.
2. Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year and who were 30 years or older on the date of the test.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Cervical Cancer Screening (CCS-AD)

2. Cervical Cancer Screening (CCS-AD) Results

PM	
Numerator	47,242
Denominator	96,437
Rate	48.99%

3. Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.
☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Cervical Cancer Screening (CCS-AD)

2. Cervical Cancer Screening (CCS-AD) Results

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-E - AD)

1. Breast Cancer Screening (BCS-E-AD) Overview

MCO name: MMM

PM name: Breast Cancer Screening (BCS-E-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling based on HEDIS MY 2023 Specifications

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Women 52–74 years as of December 31 of the measurement year.

Definition of numerator (describe):

Women who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Breast Cancer Screening (BCS-E - AD)

1. Breast Cancer Screening (BCS-E-AD) Overview

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Breast Cancer Screening (BCS-E-AD)

2. Breast Cancer Screening (BCS-E-AD) Results

PM	18–64 years	65+ years	Total
Numerator	18,362	3,531	21,893
Denominator	27,858	6,556	34,414
Rate	65.91%	53.86%	63.62%

3. Breast Cancer Screening (BCS-E-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Antidepressant Medication Management – Acute Phase (AMM-AD)

1. Antidepressant Medication Management – Acute Phase (AMM-AD) Overview

MCO name: MMM

PM name: Antidepressant Medication Management – Acute Phase (AMM-AD)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
Sampling based on HEDIS MY 2023 Specifications
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Members 18 years and older as of the index prescription start date (IPSD).

Definition of numerator (describe):
Members with at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days).

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Antidepressant Medication Management – Acute Phase (AMM-AD)	
2. Antidepressant Medication Management – Acute Phase (AMM-AD) Results	
PM	**Acute Phase**
Numerator	2,415
Denominator	4,677
Rate	51.64%
3. Antidepressant Medication Management – Acute Phase (AMM-AD) Validation Status	
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the technical specifications.	
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.	
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)	
Describe any other validation findings that affected the accuracy of the PM calculation. N/A	
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence “Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.	
EQRO recommendations for improvement of PM calculation: None.	

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

1. Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: MMM

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

Sampling based on HEDIS MY 2023 Specifications

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Children who turn 2 years of age during the measurement year.

Definition of numerator (describe):

Children who received the required doses of DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	
2. Childhood Immunization Status Combo 3 (CIS-CH) Results	
PM	**Combo 3**
Numerator	1,237
Denominator	2,842
Rate	43.53%
3. Childhood Immunization Status Combo 3 (CIS-CH) Validation Status	
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the technical specifications.	
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) ISCA review did not identify any findings specific to this measure.	
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)	
Describe any other validation findings that affected the accuracy of the PM calculation. N/A	
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.	
EQRO recommendations for improvement of PM calculation: None.	

Asthma Medication Ration: 5 to 18 (AMR-CH)

1. Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: MMM

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
Sampling based on HEDIS MY 2023 Specifications
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Children ages 5–18 years as of December 31 of the measurement year.

Definition of numerator (describe):
The number of members who have a medication ratio of ≥0.50 during the measurement year.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Asthma Medication Ration: 5 to 18 (AMR-CH)			
2. Asthma Medication Ratio: 5 to 18 (AMR-CH) Results			
PM	**5–11 Years**	**12–18 Years**	**Total**
Numerator	528	259	787
Denominator	540	279	819
Rate	97.78%	92.83%	96.09%

3. Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

1. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: MMM

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
Sampling based on HEDIS MY 2023 Specifications
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Children 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.

Definition of numerator (describe):
All children who meet the following criteria:
Numerator compliant for Rate 1—Initiation Phase, and
At least two follow-up visits on different dates of service with any practitioner, from 31-300 days (9 months) after the IPSD.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	
2. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results	
PM	**Continuation and Maintenance**
Numerator	77
Denominator	99
Rate	77.78%

3. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

PSM Results

PM	Confidence in Reported Results
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence
PM 2: Breast Cancer Screening (BCS-E[6]-AD)	High confidence
PM 3: Antidepressant Medication Management – Acute Phase (AMM-AD)	High confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	High confidence
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence

Cervical Cancer Screening (CCS-AD)

1. Cervical Cancer Screening (CCS-AD) Overview

MCO name: PSM

PM name: Cervical Cancer Screening (CCS-AD)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

[6] The Breast Cancer Screening (BCS) measure was retired for MY 2023, only the ECDS version of this measure will now be reported.

Cervical Cancer Screening (CCS-AD)

Definition of denominator (describe):
Women 24–64 years as of December 31 of the measurement year.

Definition of numerator (describe):
The percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria:

1. Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.
2. Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year ***and*** who were 30 years or older on the date of the test.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

2. Cervical Cancer Screening (CCS-AD) Results

PM	
Numerator	28,437
Denominator	51,482
Rate	55.24%

3. Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.
☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

Cervical Cancer Screening (CCS-AD)

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-E[7]-AD)

1. Breast Cancer Screening (BCS-E -AD) Overview

MCO name: PSM

PM name: Breast Cancer Screening (BCS-AD)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Women 52–74 years as of December 31 of the measurement year.

Definition of numerator (describe):
Women who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

[7] The Breast Cancer Screening (BCS) measure was retired for MY 2023, only the ECDS version of this measure will now be reported.

Breast Cancer Screening (BCS-E[7]-AD)	
2. Breast Cancer Screening (BCS-E -AD) Results	
PM	**Total**
Numerator	9,296
Denominator	13,644
Rate	68.13%

Breast Cancer Screening (BCS-E[2]-AD)	
Numerator	9,296
Denominator	13,644
Rate	68.13%

3. Breast Cancer Screening (BCS-E -AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Antidepressant Medication Management — Acute Phase (AMM-AD)

1. Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

MCO name: PSM

PM name: Antidepressant Medication Management — Acute Phase (AMM-AD)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Members 18 years and older as of the Index prescription start date (IPSD).

Definition of numerator (describe):
Members with at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

2. Antidepressant Medication Management — Acute Phase (AMM-AD) Results

PM	Acute Phase 18-64 years	Acute Phase 65+ years	Acute Phase Total
Antidepressant Medication Management — Acute Phase (AMM-AD)			
Numerator	1,465	112	1,577
Denominator	2,520	184	2,704
Rate	58.13%	60.86%	58.32%

Antidepressant Medication Management — Acute Phase (AMM-AD)

3. Antidepressant Medication Management — Acute Phase (AMM-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

1. Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: PSM

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Children who turn 2 years of age during the measurement year.

Definition of numerator (describe):
Children who received the required doses of DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	
2. Childhood Immunization Status Combo 3 (CIS-CH) Results	
PM	
Numerator	83
Denominator	2,188
Rate	3.79%

3. Childhood Immunization Status Combo 3 (CIS-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

1. Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: PSM

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Ages 5–64 as of December 31 of the measurement year and have persistent asthma.

Definition of numerator (describe):
The number of members who have a medication ratio of ≥0.50 (controller medications) during the measurement year.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Asthma Medication Ratio: 5 to 18 (AMR-CH)		
2. Asthma Medication Ratio: 5 to 18 (AMR-CH) Results		
PM	**5–11 years**	**12–18 years**
Numerator	578	288
Denominator	602	312
Rate	96.01%	92.31%

3. Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

“Validation rating” refers to the EQRO’s overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

1. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: PSM

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Children 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.

Definition of numerator (describe):
All children who meet the following criteria:
Numerator compliant for Rate 1—Initiation Phase, and
At least two follow-up visits on different dates of service with any practitioner, from 31-300 days (9 months) after the IPSD.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	
2. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results	
PM	**6-12 years Continuation and Management**
Numerator	52
Denominator	86
Rate	60.47%

3. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Triple-S Results

PM	Confidence in Reported Results
PM 1: Cervical Cancer Screening (CCS-AD)	High confidence
PM 2: Breast Cancer Screening (BCS-E -AD)	High confidence
PM 3: Antidepressant Medication Management – Acute Phase (AMM-AD)	Moderate confidence
PM 4: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)	High confidence
PM 5: Asthma Medication Ratio: 5 to 18 (AMR-CH)	High confidence
PM 6: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)	High confidence

Cervical Cancer Screening (CCS-AD)
1. Cervical Cancer Screening (CCS-AD) Overview
MCO name: Triple-S
PM name: Cervical Cancer Screening (CCS-AD)
Measure steward: ☐ Agency for Healthcare Research and Quality (AHRQ) ☐ Centers for Disease Control and Prevention (CDC) ☐ Centers for Medicare & Medicaid Services (CMS) ☒ National Committee for Quality Assurance (NCQA) ☐ The Joint Commission (TJC) ☐ No measure steward, developed by State/EQRO ☐ Other measure steward (specify): _____
Is the PM part of an existing measure set? (check all that apply) ☒ HEDIS ☒ CMS Child or Adult Core Set ☐ Other (specify):
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe): Claims data ☐ Medical records (describe): ☐ Other (specify):

Cervical Cancer Screening (CCS-AD)

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)[8]

Definition of denominator (describe):

Women 24–64 years as of December 31 of the measurement year.

Definition of numerator (describe):

The percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria:

1. Women 24–64 years of age as of December 31 of the measurement year who had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.
2. Women 30–64 years of age as of December 31 of the measurement year who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set, High Risk HPV Test Result or Finding Value Set) during the measurement year or the four years prior to the measurement year ***and*** who were 30 years or older on the date of the test.

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

2. Cervical Cancer Screening (CCS-AD) Results

PM	
Numerator	207
Denominator	411
Rate	50.37%

3. Cervical Cancer Screening (CCS-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

[8] The MCO stated in the RFI that the measure was not calculated using hybrid measure specification; however, the FAR identifies this measure as hybrid.

Cervical Cancer Screening (CCS-AD)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence
"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Breast Cancer Screening (BCS-E-AD)

1. Breast Cancer Screening (BCS-E-AD) Overview

MCO name: Triple-S

PM name: Breast Cancer Screening (BCS-E-AD)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):
_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Women 52–74 years as of December 31 of the measurement year.

Definition of numerator (describe):
Women who had one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Breast Cancer Screening (BCS-E-AD)

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

2. Breast Cancer Screening (BCS-E-AD) Results

PM	
Numerator	27,528
Denominator	42,936
Rate	64.11%

3. Breast Cancer Screening (BCS-E-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Antidepressant Medication Management — Acute Phase (AMM-AD)

1. Antidepressant Medication Management — Acute Phase (AMM-AD) Overview

MCO name: Triple-S

PM name: Antidepressant Medication Management — Acute Phase (AMM-AD)

Measure steward:
☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Members 18 years and older as of the Index prescription start date (IPSD).

Definition of numerator (describe):
Members with at least 84 days (12 weeks) of treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 total days).

Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

2. Antidepressant Medication Management — Acute Phase (AMM-AD) Results

PM	
Numerator	3,472
Denominator	7,105[9]
Rate	48.87%

[9] The denominator reported by Triple-S in the RFI and as reflected here is different than the denominator reported in the final audit report and as reflected in Appendix C of this report.

Antidepressant Medication Management — Acute Phase (AMM-AD)

3. Antidepressant Medication Management — Acute Phase (AMM-AD) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☐ High confidence ☒ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

1. Childhood Immunization Status Combo 3 (CIS-CH) Overview

MCO name: Triple-S

PM name: Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)

☐ Centers for Disease Control and Prevention (CDC)

☐ Centers for Medicare & Medicaid Services (CMS)

☒ National Committee for Quality Assurance (NCQA)

☐ The Joint Commission (TJC)

☐ No measure steward, developed by State/EQRO

☐ Other measure steward (specify):

_____

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Is the PM part of an existing measure set? (check all that apply)
☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)
☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:
☒ Not applicable (hybrid method not used)

Definition of denominator (describe):
Children who turn 2 years of age during the measurement year.

Definition of numerator (describe):
Children who received the required doses of DTaP, IPV, MMR, HiB, Hep B, VZV, PCV.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

2. Childhood Immunization Status Combo 3 (CIS-CH) Results

PM	
Numerator	219
Denominator	4,609
Rate	4.75%

3. Childhood Immunization Status Combo 3 (CIS-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).
There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.
☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
N/A

Childhood Immunization Status Combo 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV) (CIS-CH)

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Asthma Medication Ratio: 5 to 18 (AMR-CH)

1. Asthma Medication Ratio: 5 to 18 (AMR-CH) Overview

MCO name: Triple-S

PM name: Asthma Medication Ratio: 5 to 18 (AMR-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Is the PM part of an existing measure set? (check all that apply)

☒ HEDIS
☒ CMS Child or Adult Core Set
☐ Other (specify):

What data source(s) was used to calculate the measure? (check all that apply)

☒ Administrative data (describe): Claims data
☐ Medical records (describe):
☐ Other (specify):

If the hybrid method was used, describe the sampling approach used to select the medical records:

☒ Not applicable (hybrid method not used)

Definition of denominator (describe):

Ages 5–64 as of December 31 of the measurement year and have persistent asthma

Definition of numerator (describe):

The number of members who have a medication ratio of ≥0.50 (controller medications) during the measurement year.

Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

Measurement period (start/end date): January 1, 2023–December 31, 2023

Asthma Medication Ratio: 5 to 18 (AMR-CH)

2. Asthma Medication Ratio: 5 to 18 (AMR-CH) Results

PM	5–11 Years	12–18 Years
Numerator	748	421
Denominator	770	449
Rate	97.14%	93.79%

3. Asthma Medication Ratio: 5 to 18 (AMR-CH) Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation).

There were no deviations from the technical specifications.

Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results.

☐ Not applicable (ISCA not reviewed)

☒ ISCA review did not identify any findings specific to this measure.

Describe any findings from MRR that affected the reliability or validity of the PM results.

☒ Not applicable (MRR not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.

N/A

Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence

"Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.

EQRO recommendations for improvement of PM calculation: None.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

1. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Overview

MCO name: Triple-S

PM name: Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)

Measure steward:

☐ Agency for Healthcare Research and Quality (AHRQ)
☐ Centers for Disease Control and Prevention (CDC)
☐ Centers for Medicare & Medicaid Services (CMS)
☒ National Committee for Quality Assurance (NCQA)
☐ The Joint Commission (TJC)
☐ No measure steward, developed by State/EQRO
☐ Other measure steward (specify):

_____

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)
Is the PM part of an existing measure set? (check all that apply) ☒ HEDIS ☒ CMS Child or Adult Core Set ☐ Other (specify):
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe): Claims data ☐ Medical records (describe): ☐ Other (specify):
If the hybrid method was used, describe the sampling approach used to select the medical records: ☒ Not applicable (hybrid method not used)
Definition of denominator (describe): Children 6 years as of March 1 of the year prior to the measurement year to 12 years as of the last calendar day of February of the measurement year.
Definition of numerator (describe): All children who meet the following criteria: Numerator compliant for Rate 1—Initiation Phase, and At least two follow-up visits on different dates of service with any practitioner, from 31–300 days (9 months) after the IPSD.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 1, 2023–December 31, 2023

2. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Results	
PM	
Numerator	117
Denominator	184
Rate	63.59%

3. Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH) Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (such as deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). There were no deviations from the technical specifications.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed) ☒ ISCA review did not identify any findings specific to this measure.

Follow-up Care for Children Prescribed ADHD Medication C&M (ADD-CH)
Describe any findings from MRR that affected the reliability or validity of the PM results. ☒ Not applicable (MRR not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. N/A
Validation rating: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "Validation rating" refers to the EQRO's overall confidence that the calculation of the PM adhered to acceptable methodology.
EQRO recommendations for improvement of PM calculation: None.

Section 5

Information Systems Capabilities Assessment

Introduction

CMS regulations require that each MCO undergo an ISCA to enhance the review of the PMs. The focus of the review is on components of MCO information systems that contribute to claims receipt and processing, data integrity and PM production. This is to ensure that the system can collect data on Enrollee and provider characteristics and on services furnished to Enrollees through an encounter data system or other methods. The system must be able to ensure that data received from providers are accurate and complete, verify the timeliness of reported data; screen the data for consistency; and collect service information in standardized formats to the extent feasible and appropriate.

Mercer conducted the EQR ISCA review for period CY 2023. This independent review of the MCO's information systems was conducted to support the EQR mandatory activity outlined in 42 CFR § 438.358. To complete this assessment Mercer used the current version of the CMS EQR Protocol 5 — Appendix V, Attachment A, along with comprehensive enhancements to the ISCA to reflect State-specific regulations, standards, and requirements communicated to the MCOs through the contract with Puerto Rico.

Mercer's EQR ISCA process included review of submitted materials and information, as well as interviews and live systems demonstrations that were conducted virtually in July 2024. The July meetings involved participation from MCO leadership including, but not limited to directors and VPs of HEDIS, Information Technology (IT), Analytics, Payment Integrity, Audit, Operations, Network Adequacy Validation, etc.

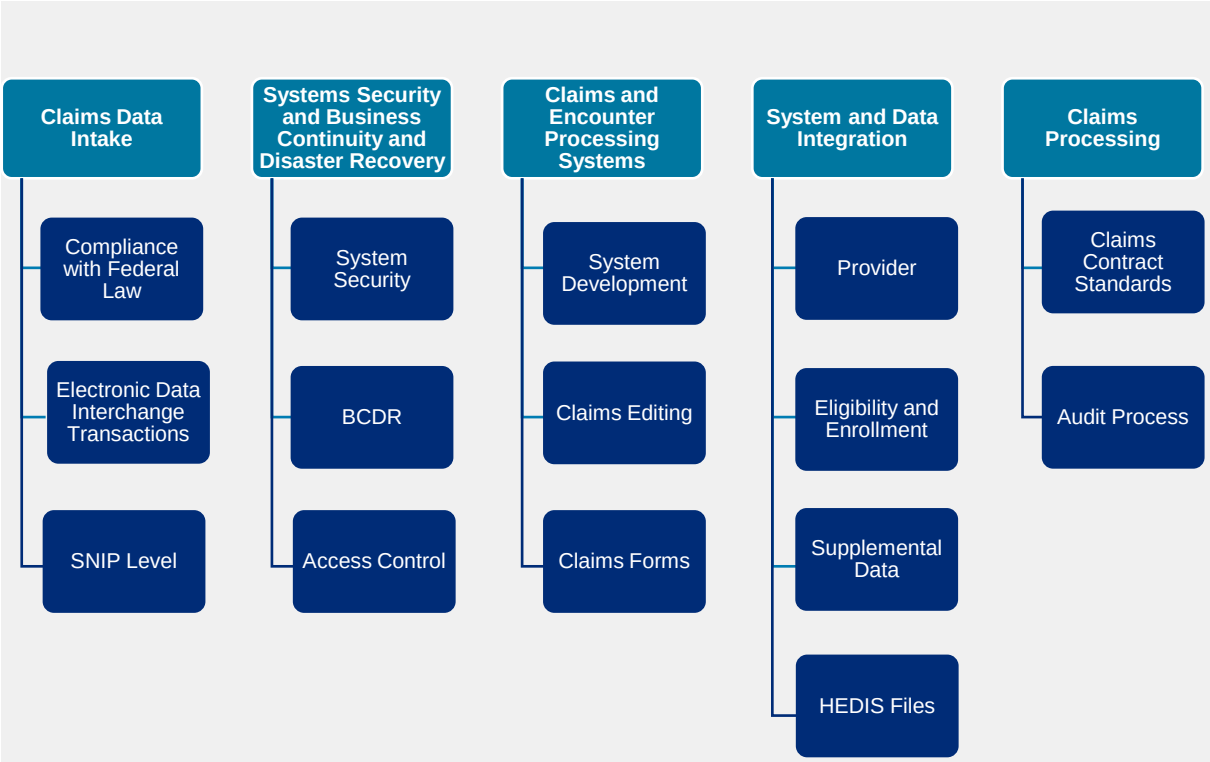
The ISCA evaluation conducted by Mercer, with Puerto Rico staff in attendance, focused on the core information systems and processes illustrated below.

Process and Documentation Reviewed

Mercer's approach to evaluating MCOs' data capabilities included four steps, outlined below:

- Establishing evaluation criteria to standardize reviews.
- Developing and distributing an RFI to collect relevant information from the MCOs.
- Analyzing the information submitted in response to the RFI.
- Conducting virtual reviews to confirm understanding and analysis of the information submitted in response to the RFI, clarifying any outstanding questions, and identifying any necessary follow-up items.

Mercer established criteria to evaluate processes and systems employed by MCOs to collect, process, pay and audit the claims as well as send encounters to ASES. These criteria fall into specific categories and subcategories as depicted in the figure below.



Overall Assessment

Mercer reviewed and evaluated MCO data systems, processes, and staffing for the managing the claims intake, adjudication, and payment as well as extracting, transforming, and loading the data into the systems and engines for PM calculation and encounter submissions. Based on the documentation submitted and information gathered during the virtual reviews, Mercer identified strengths in the systems, operations, and capabilities as well as areas where MCOs could strengthen their processes.

FMHP

Category	Area of Assessment	Findings
Claims Data Intake	Compliance with federal law as defined in 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act	The MCO's information systems comply with 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act.

Category	Area of Assessment	Findings
	Electronic Data Interchange Transactions including all applicable provisions of HIPAA and EDI standards healthcare code sets	The MCO complies with all applicable provisions of HIPAA, including EDI standards for code sets and including but not limiting to the 837, 270/271, 276/277, 820, 834, and 835. Although ASES does not require the use of 274, 275, and 278, FMHP reported no system limitations on the use of these code sets.
	SNIP Levels: **Type 1:** EDI Standard Integrity Testing **Type 2:** HIPAA Implementation Guide Requirement Testing **Type 3:** HIPAA Balance Testing **Type 4:** HIPAA Inter-Segment Situation Testing **Type 5:** HIPAA External Code Set Testing **Type 6:** Product Type/Type of Service Testing **Type 7:** Trading Partner-Specific Testing	The MCO's claims systems applies five of the seven available SNIP Level edits. This higher level helps increase the number of claims that can be auto adjudicated and decrease the risk of human errors during manual adjudication.
Systems Security and Business Continuity and Disaster Recovery	System Security including encryption, multiple factor authentication and selected security standards (NIST 800-53 R4, MARS-E 2.0, SOC 2 Type II)	The MCO complies with all applicable federal and Puerto Rico statutes and regulations regarding security standards, including encryption and employment of multi factor authentication/ identification techniques, has controls in place to safeguard data and information, and procedures for mitigating data breaches. FMHP complies with NIST 800-53 R4, MARS-E 2.0, and SOC 2 Type II.

Category	Area of Assessment	Findings
	Business Continuity and Disaster Recovery (BCDR)	The MCO tested its BCDR in October 2023 and reported all systems passed. The test was a simulated full fail-over and FMHP confirmed all systems and services could be accessed on the backup system. While FMHP reported testing its BCDR annually, staff noted that frequent power outages on the island forces FMHP to implement parts of its BCDR plan frequent. Any issues identified, whether in simulated testing or actual live scenarios, are addressed and updated immediately.
	Access Control (physical, administrative, and technical)	The MCO implemented appropriate physical, administrative, and technical controls to safeguard data and information. The MCO provides annual training on securing access to the data to its employees.
Claims and Encounter Processing Systems	System Development, new system implementation and system changes	The MCO has comprehensive, automated, and integrated information systems that include a test environment, and the MCO implements comprehensive end-to-end testing for system changes. FMHP reported stable systems with no major upgrades or changes in CY 2023.
	Claims Processing, Editing, and Payment	The MCOs has established process to receive the claims from its clearinghouse, Alpine. Alpine also scans paper claims for electronic processing. FMHP reported reviewing 100% of scanned claims to confirm all information was captured successfully. The MCO core claims system, EZCap, is configured to process and pay the claims based on the contract requirements. The MCOs use PCG Software's Virtual Examiner editing tools.

Category	Area of Assessment	Findings
	Claim Submission Formats (electronic, paper)	The MCOs can receive the claims electronically or on paper. In CY 2023, FMHP estimated having received 89.6% of claims electronically which is 4.9 percentage points less than the 94.5% reported in 2022. FMHP auto-adjudication rate is about 92%. Eight percent of the claims received have to be processed manually.
System and Data Integration	Provider Systems and Processes	The MCO has systems and processes in place to store the provider information including the provider address, specialty and taxonomy. FMHP validates a provider's NPI and taxonomy using the National Plan and Provider Enumeration System (NPPES) website during the credentialing and re-credentialing processes.
	Eligibility Systems and Processes	The MCO processes daily eligibility files within 24 hours of receipt and submits the files to its vendors and verifies its vendors' timely processing of the eligibility daily files. ASES replaced the proprietary file that it had been using to share eligibility with the MCOs at the end of 2023 with the standard 834 format. Although FMHP had to modify its processes slightly to ingest the 834 file, there was no change in how FMHP shares enrollment and eligibility files with its vendors.
	Supplemental Data and Data Integration	The MCO has established quality control and validation processes that ensure the accuracy of the data at the time of the extraction from the core systems and loading into the data warehouse. In 2023 FMHP successfully integrated supplemental lab data into reporting in the CY 2023 measures.

Category	Area of Assessment	Findings
	HEDIS files	FMHP has processes in place to extract files based on standardized layout for submission to the HEDIS vendor. FMHP uses NCQA certified MedHOK as a software vendor for processing and calculating HEDIS rates. The MCOs contracts with Aqurate Health Data Management, Inc, a NCQA licensed organization, for auditing the HEDIS calculated rates.
Management of Claims and Encounters	Claims Contract Standard: 95% of clean claims paid within 30 calendar days from the date of receipt 100% of clean claims paid within 50 calendar days from the date of receipt 90% of unclean claims paid within 90 calendar days from the date of receipt	In fiscal year (FY) 2023, FMHP paid 66% of clean claims within 30 days and 87% within 50 days. In FY 2022, FMHP reported paying 82% of clean claims within 30 days and 95% within 50 days. Although FMHP was given a corrective action to perform a root cause analysis and to address the issue, FY 2023 rates continued to decline. FMHP provided no evidence of conversations with ASES regarding the deficiency. **Required Action: Implement processes to ensure compliance with payment of 95% of clean claims within 30 days and 100% of clean claims within 50 days of receipt.**
	Encounter Process and Submission of Encounters ASES PRMMIS	The MCO has a process to create and submit the encounter file in .CLM format to ASES and met the timeliness standards each month. Once the file is accepted by ASES, all data included in the submission are accepted. The MCO also submits the encounter data to PRMMIS system and as a result may receive the rejected files that need the reprocessing for resubmission. Although FMHP has process in place to work the rejections and resubmit the file, FMHP did not provide the evidence of PRMMIS rejection report.

Category	Area of Assessment	Findings
		Required Action: Develop report and implement robust process to analyze the PRMMIS rejections to minimize the rejection. Complete analyses on the rejections to identify major topics and address the root cause of the rejections when possible. FMHP described processes for paying providers interest on all claims paid after 90 days. Although this information is retained by the MCO and can be reported on, it is not included on encounter files sent to ASES or PRMMIS.
	Audit Process and Post Payment Recovery	The MCO has process in place to audit claims. FMHP described audit processes, frequency, sampling techniques, and reporting of findings. In 2023, FMHP reported having audited 19,511 of 3,480,415 claims (0.6%). Of the 19,511 claims audited, FMHP identified issues with 1,620, which represents an 8.3% error rate. FMHP is encouraged to consider increasing the number and percentage of claims audited. FMHP is encouraged to stratify samples to include paid and denied claims, manually processed and auto adjudicated claims. The MCO has post payment recovery policies and processes. In 2023, FMHP reprocessed 35,482 claims and recovered $3,433,136.

Category	Area of Assessment	Findings
Vendor and Sub-capitated Arrangement Oversight	Oversight Activities of Capitated Providers	FMHP uses the PMG Summary Report to monitor PMG compliance with contractual requirements related to number of encounters submitted. The PMG report identifies the number of member months, number of encounters and percentage of encounters. The number of encounters submitted by each PMG must be equal to or greater than 20% of its membership. FMHP meets with PMGs quarterly to review data and encourage compliance. FMHP also provides PMGs with monthly reports of all encounter data submitted for that month. The expectation is that the PMGs validate that the list is comprehensive of all visits and will forward any missing encounter files. Although FMHP's contracts with PMGs allow FMHP to impose penalties of up to 10% for non-compliance, all penalties must be approved by ASES. FMHP has the oversight processes to ensure clinical outcomes; however, FMHP did not provide evidence of ensuring all visits by the beneficiaries are submitted as encounter data but rather relies on the panel calculation to estimate the compliance. **Required action: FMHP to develop processes to ensure all visits are submitted as encounter data**.

MMM

Category	Area of Assessment	Findings
Claims Data Intake	Compliance with Federal Law as defined in 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act.	The MCO’s information systems comply with 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act.

Category	Area of Assessment	Findings
	Electronic Data Interchange Transactions including all applicable provisions of HIPAA and EDI standards healthcare code sets.	The MCO complies with all applicable provisions of HIPAA, including EDI standards for code sets and including but not limiting to the 837, 270/271, 276/277, 820, 834, 835, and 278. Although ASES does not require the use of 274 and 275 MMM reported no system limitations on the use of these code sets.
	SNIP Levels: **Type 1:** EDI Standard Integrity Testing **Type 2:** HIPAA Implementation Guide Requirement Testing **Type 3:** HIPAA Balance Testing **Type 4:** HIPAA Inter-Segment Situation Testing **Type 5:** HIPAA External Code Set Testing **Type 6:** Product Type/Type of Service Testing **Type 7:** Trading Partner-Specific Testing	During the FY 2022 ISCA review, MMM staff could not verify if the MCO applied any SNIP level edits. MMM was required to complete gap analysis to determine which, if any, SNIP levels were applied. In FY 2023, staff verified the MCO's claims systems applies 7 of the 7 available SNIP Level edits. This is a best practice that is sure to increase the number of claims that can be auto adjudicated and decrease the risk of human errors during manual adjudication.
Systems Security and Business Continuity and Disaster Recovery	System Security – including encryption, multiple factor authentication and selected security standards (NIST 800-53 R4, MARS-E 2.0, SOC 2 Type II)	The MCO complies with all applicable federal and Puerto Rico statutes and regulations regarding security standards, including encryption and employment of multi-factor authentication/ identification techniques, has controls in place to safeguard data and information, and procedures for mitigating data breaches. MMM complies with most of the NIST 800-53 r4 security and privacy controls and continues to explore and implement improvements. MMM completed a SOC1 Type II audit in 2023. While SOC 1 audit is focused on controls relevant to financial (as opposed to SOC 2 audit which includes security, availability, processing integrity,

Category	Area of Assessment	Findings
		confidentiality, and privacy), it does include some controls and testing for systems. MMM is encouraged to continue pursuing compliance with NIST 800-53 R4 and to consider a SOC 2 Type II audit. These audits and certifications will help identify any potential gaps and ensure strong systems security.
	Business Continuity and Disaster Recovery (BCDR)	The MCO reported successful BCDR testing in September 2023. MMM also reported successful testing of QNXT in March 2023. Responsibility for DBDR testing of the QNXT system lies with Cognizant; however, MMM staff actively participated to ensure full success.
	Access Control (physical, administrative, and technical)	The MCO implemented appropriate physical, administrative, and technical controls to safeguard data and information. MMM confirmed that all staff was required to participate in annual refresher training on securing access to the data to its employees.
Claims and Encounter Processing Systems	System Development – new system implementation and system changes	The MCO has comprehensive, automated, and integrated information systems that include a test environment, and the MCO implements comprehensive end-to-end testing for system changes. MMM replaced its claims processing and medical management applications with QNXT and CareProminence respectively. MMM had been using both applications for other LOBs for many years, which helped ensure a smooth transition. All claims with dates of service prior to January 1, 2023, will continue to be processed in the old platforms. Claims with dates of service on or after

Category	Area of Assessment	Findings
		January 1, 2023, will be processed in the QNXT system.
	Claims Processing – editing and payment	The MCOs has established process to receive the claims from its clearinghouses Assertus (for electronic claims) and Applica (for paper claims). MMM's core claims system, QNXT is configured to process and pay the claims based on the contract requirements. The MMM uses claims editing tools included with QNXT as well as Optum Claims Edit System (CES), which includes National Correct Coding Initiative (NCCI) edits.
	Claim Submission Formats – electronic and paper	The MCOs can receive the claims electronically or on paper. In CY 2023, the MMM reported having received 95% of claims electronically which is the same as what was reported in CY 2022.
System and Data Integration	Provider Systems and Processes	The MCO has systems and processes in place to store the provider information including the provider address, specialty, and taxonomy. MMM staff members explained that while they collect, validate, and store each provider's taxonomy, they use the specialty code provided by ASES to distinguish provider types.
	Eligibility Systems and Processes	The MCO processes daily eligibility files within 24 hours of receipt and submits the files to its vendors and verifies its vendors' timely processing of the eligibility daily files. ASES replaced the proprietary file that it had been using to share eligibility with the MCOs at the end of CY 2023 with the standard 834. Although MMM had to modify its processes slightly to ingest the 834 file, staff reported there was no change in how MMM shares enrollment and eligibility files with its vendors.

Category	Area of Assessment	Findings
	Supplemental Data and Data Integration	The MCO has established quality control and validation processes that ensure the accuracy of the data at the time it is extracted from the core systems and integration into the data warehouse. The MCOs has processes to integrate supplemental data into the data warehouse and use for reporting. In CY 2023, MMM added the immunization registry data in CY 2023 and reported great success.
	HEDIS files	The MCO has processes in place to extract the files based on the standardized layout for submission to the HEDIS vendor for calculating the HEDIS rates. MMM contracted with Nagnoi who used HEDISTrack/Igenia software for processing and calculating HEDIS rates. MMM contracted with Attest Healthcare Advisors for auditing the HEDIS calculated rates.
Management of Claims and Encounters	Claims Contract Standard: 95% of clean claims paid within 30 calendar days from the date of receipt. 100% of clean claims paid within 50 calendar days from the date of receipt. 90% of unclean claims paid within 90calendar days from the date of receipt.	MMM did not meet the contractual standards for clean claims processing during the first half of the year. Staff explained they encountered issues during the transition from PowerMHS to QNXT; however, issues identified and MMM is again processing claims within the required timeframes.
	Encounter Process and Submission of Encounters ASES PRMMIS	The MCO has process to create and submit encounter file in .CLM format to ASES each month and met the timeliness standards each month. Once the file is accepted by ASES, all data included in the submission are accepted. The MCO also submits the encounter data to PRMMIS system. The PRMMIS system runs edits and may reject files that need reprocessing and resubmission. MMM staff described processes to resolve and resubmit all rejections.

Category	Area of Assessment	Findings
		MMM's most common rejections from the PRMMIS systems in order of volume were NPI not matched, missing/incomplete/invalid charge, and service not payable per managed care contract. MMM has a few capitated providers whose systems prohibit them from billing for $0. As such, these providers routinely bill MMM $0.01. The MMIS system will not accept these claims. **Required Action: Develop a process to ensure that all capitated services can be appropriately reported as $0 paid encounters in PRMMIS.** MMM staff members described processes for calculating and paying interest for late claims. Staff confirmed that no interest is reported to the PRMMIS or on the CLM file to ASES; however, interest payments are clearly designated as such on provider remittance advice. Additionally, this information is available in MMM systems and can be reported on, if requested.
	Audit Process and Post Payment Recovery	MMM's Claims Quality Audit Process described processes to select 6% of claims processed by each analyst each day, up to 10 claims. The audit confirms processing, financial, and payment accuracy. However, processes described by staff members did not correspond to information reported in the request for information. As an example, MMM reported having processed almost 3.5 million claims; however, the sample frame reported was 1.5 million. Staff were not able to explain why only half of the claims processed were subject to audit. In CY 2023, MMM reported having audited 1.45% of claims. It is recommended that MMM could

Category	Area of Assessment	Findings
		enhance its auditing processes by including an audit of both paid and denied claims that were automatically adjudicated. The MCO has post payment recovery policies and processes and in CY 2023, MMM recovered $2,573,470 from 8,127 claims.
Vendor and Sub-capitated Arrangement Oversight	Oversight Activities of Capitated Providers	MMM's Network Management Department uses Relisc platform to monitor PMG compliance with contractual requirements related to number of encounters submitted. Relisc provides real-time information to PMGs about compliance with key encounter data reporting metrics. Dashboards include membership, admissions and discharges, members with quality gaps, and number of reported encounters. This platform is available to providers at any time and is used by the Network Management Department to facilitate quarterly meetings with PMGs.

PSM

Category	Area of Assessment	Findings
Claims Data Intake	Compliance with Federal Law as defined in 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act	The MCO’s information systems comply with 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act.
	Electronic Data Interchange Transactions including all applicable provisions of HIPAA and EDI standards healthcare code sets.	The MCO complies with all applicable provisions of HIPAA, including EDI standards for code sets and including but not limiting to the 837, 270/271, 276/277, 820, 834, and 835. Although ASES does not require the use of 274, 275, and 278, PSM reported no

Category	Area of Assessment	Findings
		system limitations on the use of these code sets.
	SNIP Levels: **Type 1:** EDI Standard Integrity Testing **Type 2:** HIPAA Implementation Guide Requirement Testing **Type 3:** HIPAA Balance Testing **Type 4:** HIPAA Inter-Segment Situation Testing **Type 5:** HIPAA External Code Set Testing **Type 6:** Product Type/Type of Service Testing **Type 7:** Trading Partner-Specific Testing	The MCO's claims systems applies 7 of the 7 available SNIP Level edits. This is a best practice that is sure to increase the number of claims that can be auto adjudicated and decrease the risk of human errors during manual adjudication.
Systems Security and Business Continuity and Disaster Recovery (BCDR)	System Security including encryption, multiple factor authentication and selected security standards (NIST 800-53 R4, MARS-E 2.0, SOC 2 Type II)	The MCO complies with all applicable federal and Puerto Rico statutes and regulations regarding security standards, including encryption and employment of multi factor authentication/ identification techniques, has controls in place to safeguard data and information, and procedures for mitigating data breaches. PSM reported being SOC2 Type II certified.
	BCDR	PSM has a BCDR plan specific for Puerto Rico operations. PSM performs testing annually and collaborated with Humana on a full failover test in May 2023. PSM reported no issues encountered.
	Access Control (physical, administrative, and technical)	The MCO implemented appropriate physical, administrative and technical controls to safeguard data and information. PSM provides annual training on securing access to the data to its employees. PSM reported having provided training to all staff in August 2023.

Category	Area of Assessment	Findings
Claims and Encounter Processing Systems	System Development, new system implementation and system changes	The MCO has comprehensive, automated, and integrated information systems that include a test environment, and the MCO implements comprehensive end-to-end testing for system changes. PSM reported no major upgrades or changes to its systems during CY 2023.
	Claims Processing, Editing, and Payment	The MCOs has established process to receive the claims from its clearinghouses Assertus (for electronic claims) and Applica (for paper claims). PSM's core claims system, PMHS, is configured to process and pay the claims based on the contract requirements. PSM uses ClaimsXten core-system editing tools and Pilot Information System non-core editing vendor. Both core and non-core edits incorporate ASES-specific requirements, industry standard policies, and NCCI edits like procedure-to-procedure and medically unlikely edits.
	Claim Submission Formats (electronic, paper)	The MCOs can receive the claims electronically or on paper. In CY 2023, PSM reported having received 94% of claims electronically, which is more than the 91% reported in 2022. PSM also reported about 94% of dental claims are submitted electronically; however, only 85.5% of BH claims are submitted electronically.
System and Data Integration	Provider Systems and Processes	The MCO has systems and processes in place to store the provider information including the provider address, specialty and taxonomy. PSM staff explained that provider's NPI and taxonomy are validated during the credentialing and re-credentialing processes.

Category	Area of Assessment	Findings
	Eligibility Systems and Processes	The MCO processes daily eligibility files within 24 hours of receipt and submits the files to its vendors and verifies its vendors' timely processing of the eligibility daily files. ASES replaced the proprietary file that it had been using to share eligibility with the MCOs at the end of 2023 with the standard 834. Although PSM had to modify its processes slightly to ingest the 834 file, staff reported there was no change in how PSM shares enrollment and eligibility files with its vendors.
	Supplemental Data and Data Integration	The MCO has established quality control and validation processes that ensure the accuracy of the data at the time it is extracted from the core systems and integration into the data warehouse. The MCOs has processes to integrate supplemental data into the data warehouse and use for reporting.
	HEDIS Files	The MCO has processes in place to extract the files based on the standardized layout for submission to the HEDIS vendor to process the data and calculated the HEDIS rates. PSM uses OptumInsight, Inc., an NCQA certified vendor for processing and calculating HEDIS rates. PSM contracts with Aqurate Health Data Management, Inc for auditing the HEDIS calculated rates.
Management of Claims and Encounters	Claims Contract Standard: 95% of clean claims paid within 30 calendar days from the date of receipt 100% of clean claims paid within 50 calendar days from the date of receipt 90% of unclean claims paid within 90 calendar days from the date of receipt	PSM attested to paying 97.99% of clean claims within 30 calendar days and 99% of clean claims within 50 days; however, PSM missed the requirement to process 100% of clean claims within 50 days from the date of receipt by 1%.

Category	Area of Assessment	Findings
		Required Action: **Implement processes to ensure compliance with payment of 95% of clean claims within 30 days and 100% of clean claims within 50 days of receipt.**
	Encounter Process and Submission of Encounters ASES PRMMIS	The MCO has process to create and submit the encounter file in .CLM format to ASES each month and met the timeliness standards each month. Once the file is accepted by ASES, all data included in the submission are accepted. The MCO also submits the encounter data to PRMMIS system and may receive rejected files that need the reprocessing. PSM staff members said they work all rejections; however, they reported no processes to track and trend rejections. PSM should trend these rejections to determine which ones are most prevalent. This information could assist PSM with addressing these issues prior to being submitted. **Required Action: Develop processes and mechanisms to track all PRMMIS rejections.** PSM staff members confirmed that all claims paid more than 90 days from date of receipt are paid interest. PSM does not report interest paid to provider on the CML or PRMMIS submissions; however, staff reported the information is included on provider remittance advice and is available for reporting, if required.

Category	Area of Assessment	Findings
	Audit Process and Post Payment Recovery	In CY 2023, MCO audited 8,634 of 436,143 manually processed claims and reported 701 with errors. This represents an 8.1% error rate. PSM reported no processes to audit denied or auto adjudicated claims. PSM staff members explained PSM believes the risk of incorrect payment in auto-adjudicated claims is low due to PSM core system edits, specific pre-pay edits validations, pre-pay in-house query validations and post-pay validations. As such, PSM only audits manually processed claims. The MCO has post payment recovery policies and processes and in 2023, recovered $968,119 from 9,319 claims.
Vendor and Sub-capitated Arrangement Oversight	Oversight Activities of Capitated Providers	PSM staff meet with PMGs monthly to review encounter reports. PMGs have access to all reports used by PSM and are expected to self-monitor between meetings with PSM. PSM staff members say they can see that providers are accessing these reports and PSM can see improvement.

Triple-S

Category	Area of Assessment	Findings
Claims Data Intake	Compliance with Federal Law as defined in 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act	The MCO's information systems comply with 42 CFR 438.242, section 6504(a) of the Affordable Care Act and section 1903(r)(1)(F) of the Social Security Act.
	Electronic Data Interchange Transactions including all applicable provisions of HIPAA and EDI standards healthcare code sets	The MCO complies with all applicable provisions of HIPAA, including EDI standards for code sets and including but not limiting to the 837, 270/271, 276/277, 820, 834, 835, and 278. Although ASES does not require the use of 274 and 275, Triple-S reported no system limitations on the use of these code sets.
	SNIP Levels: **Type 1:** EDI Standard Integrity Testing **Type 2:** HIPAA Implementation Guide Requirement Testing **Type 3:** HIPAA Balance Testing **Type 4:** HIPAA Inter-Segment Situation Testing **Type 5:** HIPAA External Code Set Testing **Type 6:** Product Type/Type of Service Testing **Type 7:** Trading Partner-Specific Testing	The MCO's claims systems applies five of the seven available SNIP Level edits. This higher level helps increase the number of claims that can be auto adjudicated and decrease the risk of human errors during manual adjudication.
Systems Security and Business Continuity and Disaster Recovery	System Security including encryption, multiple factor authentication and selected security standards (NIST 800-53 R4, MARS-E 2.0, SOC 2 Type II)	Triple-S complies with all applicable federal and Puerto Rico statutes and regulations regarding security standards, including encryption and employment of multi factor authentication/ identification techniques, has controls in place to safeguard data and information, and procedures for mitigating data breaches. Triple-S complies with NIST 800-53 R4, MARS-E 2.0, and SOC 2 Type II.

Category	Area of Assessment	Findings
	Business Continuity and Disaster Recovery (BCDR)	The MCO performed a full failover test in August 2023 that resulted in a pass. Triple-S confirmed that its QNXT system was included in the testing and that full failover to the Azure Cloud was successful.
	Access Control (physical, administrative and technical)	The MCO implemented appropriate physical, administrative, and technical controls to safeguard data and information. The MCO provides annual training on securing access to the data to its employees.
Claims and Encounter Processing Systems	System Development, new system implementation and system changes	The MCO has comprehensive, automated, and integrated information systems that include a test environment, and the MCO implements comprehensive end-to-end testing for system changes. Triple-S attested in its RFI to having had no system changes in CY 2023; however, system diagrams presented during interviews was different than the one submitted. Triple-S staff members clarified the MCO completed a full migration from the Essette care management platform to MedCompass in November 2023. Staff confirmed heavy participation by the clinical management team.
	Claims Processing, Editing, and Payment	The MCOs has established process to receive the claims from its clearinghouse, Assertus. Assertus also scans paper claims for electronic processing. The MCO core claims system QNXT, is configured to process and pay the claims based on the contract requirements. Triple-S uses Claims Editing System (CES) from Optum as its claims editing

Category	Area of Assessment	Findings
		software as well as necessary NCCI edits.
	Claim Submission Formats (electronic, paper)	The MCOs can receive the claims electronically or on paper. In CY 2023, the MCO received 93% of claims electronically which is three percentage point lower than what was reported for FY 2022.
System and Data Integration	Provider Systems and Processes	The MCO has systems and processes in place to store the provider information including the provider address and specialty. In the FY 2022 ISCA review, Triple-S reported no validation, collection, or use of provider taxonomy. It was recommended that Triple-S review and update its policies for collecting and using taxonomy codes to align with CMS preference for the providers that have NPI. CMS stated, "To help states with this challenge, CMS will only require taxonomy codes (PROV-CLASSIFICATION-TYPE=1) for providers that have NPIs and Authorized Category of Service (PROV-CLASSIFICATION-TYPE=4) for providers that do not have NPIs." Although Triple-S staff members said Triple-S had processes to collect and validate taxonomy, documentation submitted provided no evidence. While Triple-S contract with ASES may not explicitly require collection, validation, and use of a provider taxonomy, Triple-S is strongly encouraged to implement processes to collect, validate and store provider taxonomy.

Category	Area of Assessment	Findings
	Eligibility Systems and Processes	The MCO processes daily eligibility files within 24 hours of receipt and submits the files to its vendors and verifies its vendors' timely processing of the eligibility daily files. ASES replaced the proprietary file that it had been using to share eligibility with the MCOs at the end of 2023 with the standard 834. Although Triple-S had to modify its processes slightly to ingest the 834 file, staff reported there was no change in how Triple-S shares enrollment and eligibility files with its vendors.
	Supplemental Data and Data Integration	The MCO has established quality control and validation processes that ensure the accuracy of the data at the time it is extracted from the core systems and integration into the data warehouse. The MCOs has processes to integrate supplemental data into the data warehouse and use for reporting.
	HEDIS Files	The MCO has processes in place to extract the files based on the standardized layout for submission to the HEDIS vendor to process the data and calculated the HEDIS rates. Triple-S uses Nagnoi's STARSTrack certified software vendor for processing and calculating HEDIS rates. The MCOs contracts with NCQA licensed organization, Aqurate Health Data Management, Inc. for auditing the HEDIS calculated rates.

Category	Area of Assessment	Findings
Management of Claims and Encounters	Claims Contract Standard: 95% of clean claims paid within 30 calendar days from the date of receipt 100% of clean claims paid within 50 calendar days from the date of receipt 90% of unclean claims paid within 90 calendar days from the date of receipt	While Triple-S exceeded the contractual standards for processing 95% of clean claims within 30 days by four percentage points, Triple-S reportedly processed 99.40% of clean claims within 50 days, which is 0.60% less than the required 100%. Triple-S staff members described processes for calculating and paying interest on all claims paid after 90 days. **Required Action: Implement processes to ensure 100% of all clean claims are processed within 50 days of receipt.**
	Encounter Process and Submission of Encounters ASES PRMMIS	Triple-S has process to create and submit the encounter file in .CLM format to ASES each month and met the timeliness standards each month. Once the file is accepted by ASES, all data included in the submission are accepted. The MCO also submits the encounter data to PRMMIS system and, as a result, may receive the rejected files that need the reprocessing for resubmission. The MCOs most common rejections from the PRMMIS systems include not matching NPI or charges that exceed fee schedules per contract. Triple-S has a few capitated providers whose systems prohibit them from billing for $0. As such, these providers routinely bill Triple-S $0.01. The MMIS system will not accept these claims. **Required Action: Develop a process to ensure that all capitated services can be appropriately reported as $0 paid encounters in PRMMIS.**

Category	Area of Assessment	Findings
		Staff confirmed that no interest is reported to the PRMMIS or on the CLM file to ASES; however, interest payments are clearly designated as such on provider remittance advice. Additionally, this information is available and can be reported on, if requested.
	Audit Process and Post Payment Recovery	The MCO has process in place to audit claims; however, documentation provided included little details regarding how or how many samples are selected for audit. During the interviews, staff described high-dollar thresholds that require additional reviews and post payment audits by the FWA departments, staff could not explain how or how many samples are selected for audit. The MCO's RFI response reported that Triple-S audited 39,823 of the 5,996,530 processed (0.6%). **Required Action: Revise P&Ps to clearly describe how, how frequently, and how many claims are selected for audit.** The MCO has post payment recovery policies and processes and in 2023, Triple-S recovered $4,902,432 from 13,820 claims.
Vendor and Sub-Capitated Arrangement Oversight	Oversight Activities of Capitated Providers	Triple-S staff members described processes and reports used for monitoring capitated providers' encounter submissions. Leakage reports identify when a member assigned to one urgent care facility gets care at a second urgent care facility. Staff explained that the fees paid to the second facility are subtracted from the contracted facility's capitation payment. Triple-S also shares information on the number of encounters submitted each month so that the providers

Category	Area of Assessment	Findings
		can confirm all encounters have been submitted. Other reports used by Triple-S to monitor capitated providers' submission of encounters include utilization reports, claimed cost amount, service units, membership, cost per service, cost per member, and service per 1,000 members.

Section 6

Review of Compliance with Medicaid Managed Care Regulations

Introduction

To complete the review of compliance with Medicaid managed care regulations, Mercer utilized the mandatory compliance validation protocol (Protocol 3) to determine the extent to which MCPs comply with federal standards set forth in 42 CFR 438, part 56, 100, 114, Subparts D, QAPI, state standards, and MCP contract requirements. This review focuses on the previous EQR cycle findings that were not met or partially met. The MCPs were required to create corrective action plans (CAPs) to become compliant. The tables provide the overall compliance rating from the 2022-2023 and follow-up 2023-2024 EQR CAP review cycle.

MCO

		Review Cycle 22-23				Review Cycle 23-24			
Standard Reviewed by the EQRO	**Overall Compliance Rating**	**FMHP**	**MMM**	**PSM**	**Triple-S**	**FMHP**	**MMM**	**PSM**	**Triple-S**
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	83%	67%	100%	100%	100%	67%	100%	100%
	§438.100 Enrollee Rights Requirements	75%	80%	75%	90%	90%	80%	75%	90%
Provider Network	§438.206 Availability of Services	100%	100%	100%	63%	100%	100%	100%	63%
	§438.207 Assurances of Adequate Capacity of Services	100%	100%	100%	100%	100%	100%	100%	100%
	§438.214 Provider Selection	83%	83%	83%	100%	100%	83%	83%	100%
	§438.230 Subcontractual Relationships and Delegation	100%	100%	75%	100%	100%	100%	100%	100%
Care Management	§438.208 Coordination and Continuity of Care	94%	83%	83%	89%	94%	89%	89%	89%

		Review Cycle 22-23				Review Cycle 23-24			
	§438.224 Confidentiality	100%	100%	100%	50%	100%	100%	100%	50%
Utilization Management	§438.210 Coverage and Authorization of Services	92%	92%	92%	92%	100%	92%	92%	100%
	§438.114 Emergency and Post-Stabilization Services	50%	100%	100%	100%	100%	100%	100%	100%
	§438.236 Practice Guidelines	100%	100%	100%	100%	100%	100%	100%	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%	89%	93%	93%	93%	89%	93%	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%
	§438.330 QAPI	100%	100%	94%	100%	100%	100%	94%	100%
MCO Average		**91%**	**92%**	**93%**	**91%**	**98%**	**93%**	**95%**	**92%**

MAO

		Review Cycle 22-23				Review Cycle 23-24			
Standard Reviewed by the EQRO	**Subpart D and QAPI Standard**	**Humana**	**MCS**	**MMM Platino**	**Triple-S Platino**	**Humana**	**MCS**	**MMM Platino**	**Triple-S Platino**
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	100%	100%	100%	100%	100%	100%	100%	100%
	§438.100 Enrollee Rights Requirements	85%	90%	90%	90%	85%	90%	90%	90%
Provider Network	§438.206 Availability of Services	75%	75%	100%	50%	75%	75%	100%	50%
	§438.207 Assurances of Adequate Capacity of Services	100%	100%	100%	100%	100%	100%	100%	100%
	§438.214 Provider Selection	100%	100%	50%	100%	100%	100%	50%	100%
	§438.230 Sub-contractual	100%	100%	100%	100%	100%	100%	100%	100%

		Review Cycle 22-23				Review Cycle 23-24			
	Relationships and Delegation								
Care Management	§438.208 Coordination and Continuity of Care	100%	100%	100%	50%	100%	100%	100%	50%
	§438.224 Confidentiality	100%	100%	100%	100%	100%	100%	100%	100%
Utilization Management	§438.210 Coverage and Authorization of Services	80%	80%	80%	100%	100%	80%	80%	100%
	§438.114 Emergency and Post-Stabilization Services	50%	100%	100%	100%	50%	100%	100%	100%
	§438.236 Practice Guidelines	50%	100%	100%	100%	50%	100%	100%	100%
Grievances and Appeals	§438.228 Grievance and Appeal Systems	75%	93%	71%	93%	75%	96%	75%	93%
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%
	§438.330 QAPI	100%	100%	100%	100%	100%	100%	100%	100%
MAO Average		**87%**	**96%**	**92%**	**92%**	**88%**	**96%**	**93%**	**92%**

EQRO Cycle 2023-2024 CAP Review

The tables below illustrate the CAP areas and numbers closed out during the 2023-2024 EQR Cycle to provide a sense of the MCP's progress toward full compliance with expectations by review area.

MCO CAP Review

MCO Corrective Action Plan

EQRO Review Sections	FMHP		MMM		PSM		Triple-S	
	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023
Enrollee Rights and Protections	4	3	3	0	3	0	1	0
Provider Network	1	1	1	0	5	2	2	0
Care Management	2	0	3	1	3	1	4	0
Utilization Management	2	2	1	0	1	0	1	1
Grievance and Appeals	2	0	2	0	2	0	2	0
Quality Improvement and Assessment	0	0	0	0	1	0	0	0
Total	**11**	**6**	**10**	**1**	**15**	**3**	**10**	**1**

MAO CAP Review

MAO Corrective Action Plan

EQRO Review Sections	Humana		MCS		MMM		Triple-S	
	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023
Enrollee Rights and Protections	1	0	1	0	1	0	1	0
Provider Network	3	0	1	0	2	0	2	0
Care Management	0	0	0	0	0	0	2	0
Utilization Management	4	2	2	0	2	0	0	0
Grievance and Appeals	6	0	2	1	6	1	2	0
Quality Improvement and Assessment	0	0	0	0	0	0	0	0
Total	**14**	**2**	**6**	**1**	**11**	**1**	**7**	**0**

Review Process

To kick off the EQR, Mercer developed a timeline that chronologically summarized the EQR deliverables and their due dates and distributed it to the Managed Care Plan (MCP) staff. The CAP review encompassed the MCP's CY 2023 operations. The 2024 EQR process began on February 29, 2024, when Mercer delivered the request for information (RFI) to the MCPs. Mercer used a HIPAA compliant secure file transfer protocol site, SharePoint, to allow a secure exchange of information among Mercer, PRMP, and the MCPs. MCP materials were uploaded to the SharePoint site by April 1, 2024. The desk review was a

comprehensive analysis of P&Ps and supporting documents related to CMS Federal Regulations and Puerto Rico contract standards.

To evaluate the MCP compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCP's CAP items and supporting documentation, organizational charts, training materials, P&Ps, and other supporting documentation. This review was conducted based on information submitted by the MCP's through the RFI and through virtual meetings held between June 3–27, 2024.

Compliance Review Tools

Mercer utilized a comprehensive EQR compliance review tool (tool) adapted from CMS protocols for the compliance section of the review. The tool design included state standards reflecting key issues and Puerto Rico priorities. The tool assisted the reviewers in coordinating the review process in a logical manner, consistent with the flow of the BBA regulations. The review tool for compliance included only CAP areas for CY 2023.

Per 42 CFR 438.360, Nonduplication of Mandatory Activities, it is not a part of the Puerto Rico Quality Strategy to receive the Platino Plans Medicare Quality Improvement Organization reports and review against the Medicaid EQR activities. Puerto Rico may consider this in the future for addition to the Quality Strategy for the Platino review cycle.

Compliance Review Results

The Appendices A and B provide the health plan-specific protocol 3 report sections, present the topics reviewed, the health plan team members who participated in the review, as well as the findings and recommendations. Summary results of the analysis make up this area of the report.

Scoring Methodology

For each regulatory/contractual requirement for each program, a three-point scoring system was used. Scores are defined in the following table.

Compliance Level Definitions	
Met	All required documentation is present, MCP staff provides responses that are consistent with each other and with the documentation, or documents and/or MCP staff provide evidence of compliance with regulatory or contractual provisions.

Compliance Level Definitions	
Partially Met	Any one of the following may be applicable: **Section 1** Documentation to substantiate compliance with the entirety of the regulatory or contractual provision was provided. MCP staff interviews, however, provided information that was not consistent with documentation provided. **Section 2** Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided although MCP staff interviews provided information consistent with compliance with all regulatory or contractual provisions. **Section 3** Documentation to substantiate compliance with some but not all of the regulatory or contractual provision was provided, and MCP staff interviews provided information inconsistent with compliance with all regulatory or contractual provisions.
Not Met	No documentation is present and MCP staff have little to no knowledge of processes or issues that comply with regulatory or contractual provisions.

An overall percentage compliance score for each of the standards was calculated based on the total points scored divided by total possible points (Met = 3 point, Partially Met = 2 points, and Not Met = 1 points). In addition, an overall percentage compliance score for all standards was calculated to give each standard equal weighting. The total percentages from each standard were divided by the total number of standards reviewed. For each area identified as Partially Met or Not Met, the health plan was required to submit a CAP in a format agreeable to Puerto Rico.

Observations and Recommendations from Previous EQR

Mercer reviewed the last available Technical Report from the previous EQRO for the 2018-2022 review period. As a part of the 2023 RFI, Mercer requested CAPs and supporting documentation from the health plans from the last review cycle. Although a summary of findings was provided at the end of each review session, many of the MCPs waited for the final report to come out before making changes and thus did not initiate or complete changes in CY 2023.

The health plans made some progress towards compliance. Many of the interventions across all MCPs were ongoing within CY 2024. For this reason, those CAPs were left as unchanged in their scoring. Some CAP interventions were fully implemented in CY 2023 and thus marked as MET for scoring.

Aggregate Health Plan Recommendations

During the virtual reviews the MCPs were provided a summary of findings and encouraged to continuing implementing changes to close out the CAPs rather than waiting for the final reports. Mercer recommends that all the MCPs continue to work their CAPs, implement interventions and operationalize changes to be in compliance with the federal regulations and contractual requirements in 2024. This includes having a system to ensure oversite of these changes and monitoring for compliance.

Health Plan-Specific Compliance Review Results

Mercer presents Health Plan CY 2023-2024 Compliance Review results by individual health plan in this section. For detailed findings and recommendations for all MCPs see Appendices A and B. Mercer used the technical scores along with qualitative review results to outline high-level strengths, findings, and recommendations. Scores for Review Cycle 2023-2024 are below as well as Review Cycle 2022-2023 for comparison for improvement by area.

MCOs

FMHP

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on June 24, 2024.

FMHP Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Review Cycle 2022-2023	Review Cycle 2023-2024
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	83%	**100%**
	§438.100 Enrollee Rights Requirements	75%	**90%**
Provider Network	§438.206 Availability of Services	100%	**100%**
	§438.207 Assurances of Adequate Capacity of Services	100%	**100%**
	§438.214 Provider Selection	83%	**100%**
	§438.230 Sub Contractual Relationships and Delegation	100%	**100%**
Care Management	§438.208 Coordination and Continuity of Care	94%	**94%**
	§438.224 Confidentiality	100%	**100%**
Utilization Management	§438.210 Coverage and Authorization of Services	92%	**100%**
	§438.114 Emergency and Post-stabilization Services	50%	**100%**
	§438.236 Practice Guidelines	100%	**100%**
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%	**93%**
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	**100%**
	§438.330 QAPI	100%	**100%**
MCO Average		**91%**	**98%**

MMM GHP

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on June 25, 2024.

MMM GHP Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Review Cycle 2022-2023	Review Cycle 2023-2024
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	67%	**67%**
	§438.100 Enrollee Rights Requirements	80%	**80%**
Provider Network	§438.206 Availability of Services	100%	**100%**
	§438.207 Assurances of Adequate Capacity of Services	100%	**100%**
	§438.214 Provider Selection	83%	**83%**
	§438.230 Sub contractual Relationships and Delegation	100%	**100%**
Care Management	§438.208 Coordination and Continuity of Care	83%	**89%**
	§438.224 Confidentiality	100%	**100%**
Utilization Management	§438.210 Coverage and Authorization of Services	92%	**92%**
	§438.114 Emergency and Post-stabilization Services	100%	**100%**
	§438.236 Practice Guidelines	100%	**100%**
Grievances and Appeals	§438.228 Grievance and Appeal Systems	89%	**89%**
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	**100%**
	§438.330 QAPI	100%	**100%**
MCO Average		**92%**	**93%**

PSM

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on June 26, 2024.

PSM Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Review Cycle 2022-2023	Review Cycle 2023-2024
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	100%	**100%**
	§438.100 Enrollee Rights Requirements	75%	**75%**
Provider Network	§438.206 Availability of Services	100%	**100%**
	§438.207 Assurances of Adequate Capacity of Services	100%	**100%**
	§438.214 Provider Selection	83%	**83%**
	§438.230 Sub contractual Relationships and Delegation	75%	**100%**
Care Management	§438.208 Coordination and Continuity of Care	83%	**89%**
	§438.224 Confidentiality	100%	**100%**
Utilization Management	§438.210 Coverage and Authorization of Services	92%	**100%**
	§438.114 Emergency and Post-stabilization Services	100%	**100%**
	§438.236 Practice Guidelines	100%	**100%**
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%	**93%**
Quality Improvement and Assessment	§438.242 Health Information Systems	94%	**94%**
	§438.330 QAPI	100%	**100%**
MCO Average		**93%**	**95%**

Triple-S GHP

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on June 27, 2024.

Triple-S Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Review Cycle 2022-2023	Review Cycle 2023-2024
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	100%	**100%**
	§438.100 Enrollee Rights Requirements	90%	**90%**
Provider Network	§438.206 Availability of Services	63%	**63%**
	§438.207 Assurances of Adequate Capacity of Services	100%	**100%**
	§438.214 Provider Selection	100%	**100%**
	§438.230 Sub contractual Relationships and Delegation	100%	**100%**
Care Management	§438.208 Coordination and Continuity of Care	89%	**89%**
	§438.224 Confidentiality	50%	**50%**
Utilization Management	§438.210 Coverage and Authorization of Services	92%	**100%**
	§438.114 Emergency and Post-stabilization Services	100%	**100%**
	§438.236 Practice Guidelines	100%	**100%**
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%	**93%**
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	**100%**
	§438.330 QAPI	100%	**100%**
MCO Average		**91%**	**92%**

MAOs

Humana

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on June 3, 2024.

Humana Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Review Cycle 2022-2023	Review Cycle 2023-2024
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	85%	**85%**
	§438.100 Enrollee Rights Requirements	75%	**75%**
Provider Network	§438.206 Availability of Services	100%	**100%**
	§438.207 Assurances of Adequate Capacity of Services	100%	**100%**
	§438.214 Provider Selection	100%	**100%**
	§438.230 Sub contractual Relationships and Delegation	100%	**100%**
Care Management	§438.208 Coordination and Continuity of Care	100%	**100%**
	§438.224 Confidentiality	80%	**100%**
Utilization Management	§438.210 Coverage and Authorization of Services	50%	**50%**
	§438.114 Emergency and Post-stabilization Services	50%	**50%**
	§438.236 Practice Guidelines	75%	**75%**
Grievances and Appeals	§438.228 Grievance and Appeal Systems	100%	**100%**
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	**100%**
	§438.330 QAPI	85%	**85%**
MCO Average		**87%**	**88%**

MCS

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on June 4, 2024.

MCS Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Review Cycle 2022-2023	Review Cycle 2023-2024
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	100%	**100%**
	§438.100 Enrollee Rights Requirements	90%	**90%**
Provider Network	§438.206 Availability of Services	75%	**75%**
	§438.207 Assurances of Adequate Capacity of Services	100%	**100%**
	§438.214 Provider Selection	100%	**100%**
	§438.230 Sub contractual Relationships and Delegation	100%	**100%**
Care Management	§438.208 Coordination and Continuity of Care	100%	**100%**
	§438.224 Confidentiality	100%	**100%**
Utilization Management	§438.210 Coverage and Authorization of Services	80%	**80%**
	§438.114 Emergency and Post-stabilization Services	100%	**100%**
	§438.236 Practice Guidelines	100%	**100%**
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%	**96%**
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	**100%**
	§438.330 QAPI	100%	**100%**
MCO Average		**96%**	**96%**

MMM Platino

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on June 5, 2024.

MMM Platino Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Review Cycle 2022-2023	Review Cycle 2023-2024
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	100%	**100%**
	§438.100 Enrollee Rights Requirements	90%	**90%**
Provider Network	§438.206 Availability of Services	100%	**100%**
	§438.207 Assurances of Adequate Capacity of Services	100%	**100%**
	§438.214 Provider Selection	50%	**50%**
	§438.230 Sub contractual Relationships and Delegation	100%	**100%**
Care Management	§438.208 Coordination and Continuity of Care	100%	**100%**
	§438.224 Confidentiality	100%	**100%**
Utilization Management	§438.210 Coverage and Authorization of Services	80%	**80%**
	§438.114 Emergency and Post-stabilization Services	100%	**100%**
	§438.236 Practice Guidelines	100%	**100%**
Grievances and Appeals	§438.228 Grievance and Appeal Systems	71%	**75%**
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	**100%**
	§438.330 QAPI	100%	**100%**
MCO Average		**92%**	**93%**

Triple-S Platino

Mercer reviewed all documents that were submitted in support of the compliance validation process. In addition, Mercer conducted a virtual review on June 6, 2024.

Triple-S Platino Compliance Performance Validation Scores

Standard Reviewed by the EQRO	Overall Compliance Rating	Review Cycle 2022-2023	Review Cycle 2023-2024
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations	100%	**100%**
	§438.100 Enrollee Rights Requirements	90%	**90%**
Provider Network	§438.206 Availability of Services	50%	**50%**
	§438.207 Assurances of Adequate Capacity of Services	100%	**100%**
	§438.214 Provider Selection	100%	**100%**
	§438.230 Sub contractual Relationships and Delegation	100%	**100%**
Care Management	§438.208 Coordination and Continuity of Care	50%	**50%**
	§438.224 Confidentiality	100%	**100%**
Utilization Management	§438.210 Coverage and Authorization of Services	100%	**100%**
	§438.114 Emergency and Post-stabilization Services	100%	**100%**
	§438.236 Practice Guidelines	100%	**100%**
Grievances and Appeals	§438.228 Grievance and Appeal Systems	93%	**93%**
Quality Improvement and Assessment	§438.242 Health Information Systems	100%	**100%**
	§438.330 QAPI	100%	**100%**
MCO Average		**92%**	**92%**

Section 7

2023 Quality Strategy Findings and Recommendations

Goal: 1. Improve Preventative Care Screening, Access to Care and Utilization of Health Services for all Plan Vital MCO Enrollees

Mercer selected PMs from MY 2023 to review a snapshot of preventive care screening, access to care, and utilization measures.

Improve Preventative Care Screenings					
Childhood Immunization Status (CIS)	**FMHP Rates**	**MMM Rates**	**PSM Rates**	**Triple-S Rates**	**EQRO Narrative and Suggestions for the State**
DTaP	4.31%	54.19%	17.32%	20.11%	MMM Preformed higher than the other MCOs for immunization measures. Puerto Rico has an EPSDT PIP in place to improve EPSDT screening rates. It is recommended that Puerto Rico review this PIP and add improvement of CIS rates as well as preventive visits. Puerto Rico may also consider provider and member outreach campaigns focusing on improving CIS and pediatric preventive visits.
Hepatitis A	48.59%	83.67%	75.37%	65.81%	
Hepatitis B	2.31%	57.92%	6.31%	8.55%	
HiB	19.50%	73.86%	41.77%	45.71%	
Influenza	3.87%	15.24%	10.92%	9.83%	
IPV	11.69%	65.34%	21.62%	28.42%	
MMR	38.07%	82.86%	68.10%	68.6%	
Pneumococcal Conjugate	4.34%	51.27%	16.54%	20.16%	
Rotavirus	6.95 %	53.32%	14.35%	18.85%	
VZV	37.08%	81.84%	67.55%	67.93%	
Immunizations for Adolescents (IMA) Combination #1	46.16%	80.44%	53.21%	59.95%	

Improve Access to Care					
	FMHP Rates	MMM Rates	PSM Rates	Triple-S Rates	EQRO Narrative and Suggestions for the State
Prenatal and Postpartum Care					Triple-S performed higher than the other MCOs and it was the only plan to use the Hybrid methodology to review rates with medical records. It is recommended that Puerto Rico consider requiring hybrid methodology for this measure to have more accurate results for all MCOs.
Prenatal Care	16.79%	59.43%	40.17%	77.86% (Hybrid))	
Postpartum Care	19.95%	44.21%	29.74%	54.5% (Hybrid)	
Improve Access to Care — Initiation and Engagement of Substance Use Disorder Treatment (IET)					FMHP rates are higher than the other MCOs for initiation of Alcohol and Opioid treatment. The MCOs reported out on different age breakouts for the measure. It is recommended Puerto Rico standardize required reporting of age break outs.
IET Initiation — Alcohol (Total)	71.48%	29.53%	30.72%	27.56%	
13 Years–17 Years	---	---	50.0%	27.27%	
18 Years–64 Years	71.48%	26.65%	30.6%	29.29%	
65+ Years	67.86%	---	---	---	
Initiation — Opioid (Total)	---	45.89%	46.72%	50.96%	
13 Years–17 Years	---	60%	---	66.67%	
18 Years–64 Years	94.59%	45.60%	46.72%	51.65%	
65+ Years	100%	---	---	---	

Improve Utilization					
	FMHP Rates	MMM Rates	PSM Rates	Triple-S Rates	EQRO Narrative and Suggestions for the State
Well-Child Visits in the First 30 months of Life (W30)					MMM Preformed higher than the other MCO on this measure. There is an EPSDT PIP in place to improve EPSDT screening rates. It is recommended that Puerto Rico review this PIP and add preventive visits. Puerto Rico may also consider provider and member outreach campaigns focusing on pediatric preventive visits.
Age 15 Months	0.56%	18.20%	14.79%	9.49%	
Age 15 Months–30 Months	11.53%	54.68%	44.42%	42%	
Child and Adolescent Well-Care Visits (WCV)					MMM Preformed higher than the other MCOs for this measure. There is an EPSDT PIP in place to improve EPSDT screening rates. It is recommended that Puerto Rico review this PIP and add preventive visits. Puerto Rico may also consider provider and member outreach campaigns focusing on pediatric preventive visits.
3 Years–11 Years	19%	59.22%	52.33%	49.07%	
12 Years–17 Years	14.74%	48.88%	43.88%	41.77%	
18 Years–21 Years	7.84%	31.06%	30.16%	28.31%	
Total	15.32%	49%	44.25%	41.83%	

Goal: 2. Improve Quality of Care and Health Services Provided to all Plan Vital Enrollees Through the HCHN Program

Puerto Rico has removed HCHN from the MCO HCIP contract in 2023. While this is no longer apart of the HCIP, Puerto Rico is reviewing members through other initiatives. Puerto Rico is updating their Quality Strategy to reflect the contractual changes.

Goal: 3. Improve Enrollee Satisfaction with Provided Services and Primary Care Experience

Mercer reviewed the MCO MY 2023 the Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS surveys are sent out randomly to Enrollees to rate their health plan satisfaction with several preselected measures. A total of six (three Adult and three Child) Enrollee survey responses covering satisfaction with personal doctor, all healthcare, and health plan are displayed below.

It is recommended for Puerto Rico to review the health plans with lower CAHPS ratings and request information of how the plans are responding to the annual CAHPS surveys and planned interventions focused on improvement.

Quality Strategy Expectation	CAHPS Results			
	FMHP	MMM	PSM	Triple-S
CAHPS Rating of Personal Doctor	Adult: 87.6% Child: 91.6%	Adult: 74.6% Child: 84.3%	Adult: 89.4% Child: 94.4%	Adult: 66.7% Child: 74.4%
CAHPS Rating of All Healthcare	Adult: 82.9% Child: 89.2%	Adult: 68.5% Child: 73.1%	Adult: 84.3% Child: 89.1%	Adult: 52.3% Child: 53.0%
CAHPS Rating of Health Plan	Adult: 87.0% Child: 90.3%	Adult: 74.7% Child: 76.6%	Adult: 85.3% Child: 90.2%	Adult: 70.3% Child: 64.7%

Section 8
Network Adequacy Validation

EQR Objectives

CMS introduced a new Protocol 4 in 2023 as a required EQR protocol for Medicaid Programs to ensure that MCOs maintain a network of providers and timely access to care for Enrollees. Network Adequacy standards were selected to validate to ensure that the MCOs collect reliable and valid data use sound methods to assess the adequacy of the network and produce accurate results. For the CY 2022-2023 technical report, Mercer reviewed the network standards and provided feedback to Puerto Rico using MCO self-reported data. The final report was provided to Puerto Rico in CY 2024, thus there is not an update during the review for CY 2023 of any changes.

Plan Vital MCOs will be included in the EQR review. The Platino MAO plans do not have network adequacy standards in their contract. In future years, Puerto Rico will be reviewing the CMS Medicare Network reports to review for compliance.

Network Adequacy Standards

The following tables present the 2023 Network Adequacy standards for the MCOs.

Provider-to-Enrollee Ratios

Standard(s)
PCP 1:1,700 Enrollees
Gynecologist as PCP 1:2,800 (Female Enrollees 12 years and older)
Hospitals 1:50,000 Enrollees

Provider Per Municipality Requirements

Standard(s)
At least two Adult PCPs and one Pediatric PCPs, in each municipality
At least one Psychiatrist, Psychologist, Licensed Clinical Social Worker, or other Licensed BH Provider in each municipality

Required Network Provider Facilities

Standard(s)
FQHC One (1)
All Government Healthcare Facilities (9)
All Psychiatric Hospitals 12 (4 psychiatric, 8 with psychiatric beds)
Available Emergency Stabilization Units
Available Psychiatric Partial Hospitalization Facilities

Time and Distance Standards

Standard(s)
PCP — Adult Urban/Non-Urban: at least two PCPs within 15 miles/30 minutes
PCP — Pediatric Urban/Non-Urban: at least two PCPs within 15 miles/30 minutes
PCP — OB/GYN Urban/Non-Urban: at least two OBGYNs within 15 miles/30 minutes
High Volume Specialty Care Provider — Adult Urban: one of each type within 30 miles/60 minutes Non-Urban: one of each type within 45 miles/90 minutes
High Volume Specialty Care Provider — Pediatric Urban: one of each type within 30 miles/60 minutes Non-Urban: one of each type within 45 miles/90 minutes
Adult and Pediatric Dental Providers Urban: one of each type within 30 miles/60 minutes Non-Urban: one of each type within 45 miles/90 minutes
Adult and Pediatric MH Providers- Psychologist Urban/Non-Urban: at least one within 15 miles/30 minutes
Adult and Pediatric MH Providers- Psychiatrist Urban/Non-Urban: at least one within 15 miles/30 minutes

Standard(s)
Adult and Pediatric MH Providers **–** Licensed Clinical Social Worker or Licensed Professional Counselor Urban/Non-Urban: at least within 15 miles/30 minutes
Adult and Pediatric SUD Providers — Detoxification and rehabilitation Non-Urban: at least one within 45 miles/90 minutes
Adult and Pediatric SUD Providers — Intensive Outpatient (IOP) **or** Partial Hospitalization (PHP) Urban: at least one 30 miles/60 minutes Non-Urban: at least one within 45 miles/90 minutes
Hospitals Urban: one Hospital within 30 miles/60 minutes. Non-Urban: one Hospital within 45 miles/90 minutes
Emergency Room (either Hospital or Freestanding) Urban/Non-Urban: one Emergency Room within 20 miles/30 minutes

Protocol 4 Network Adequacy Validation CY 2023-2024

Mercer's EQR Network Adequacy Validation process included review of submitted materials and information from the RFI, as well as two sessions with MCO staff interviews and live systems demonstrations that were conducted virtually in June and July 2024. The July meetings involved participation from MCO leadership including, but not limited to directors and Information Technology (IT), Analytics, Audit, Operations, Network Adequacy Validation, etc.

Mercer used Quarter 4, CY 2023 data, information provided in the RFI, and post interview submissions to complete the review.

For 2023, the Puerto Rico Network Adequacy Standards in the Plan Vital contract include:

- Provider-to-Enrollee Ratios
- Provider Per Municipality Requirements
- Required Network Provider Facilities

Limitations of Data and MCO oversite include Provider to Enrollee Ratios. ASES has contracted with an enrollment broker to assign PCPs and oversee ratios for each MCO. The MCOs do not make provider assignment. Therefore, the Network Validation does not cover this standard.

Summary of Network Adequacy Technical Data Collection

To address this request, Mercer reviewed MCO completed RFIs, supporting documentation and reports to complete a desk review and prepare for the virtual ISCA and ask any supplemental questions during the virtual on-site review. Mercer used the CMS Protocol 4 worksheets to validate and score the MCOs based on the CMS Validation Rating Scale.

Validation Rating:

To determine the validation rating Mercer evaluated and assessed the data and methods used by MCOs to calculate results generated for each network adequacy category. The EQRO's validation rating reflects the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis and interpretation of the network adequacy indicator.

High confidence	Moderate confidence	Low confidence	No confidence
90.0% or greater	51.0% to 89.9%	10.0% to 49.9%	Less than 10%

Analysis and Conclusions

Provider-to-Enrollee Ratios

MCO	Network Validation Rating for 2023
FMHP	High confidence
MMM	High confidence
PSM	High confidence
Triple-S	High confidence

Provider Per Municipality Requirements

MCO	Network Validation Rating for 2023
FMHP	High confidence
MMM	High confidence
PSM	High confidence
Triple-S	High confidence

Required Network Provider Facilities

MCO	Network Validation Rating for 2023
FMHP	Moderate Confidence
MMM	High confidence
PSM	Moderate Confidence
Triple-S	Moderate Confidence

Time and Distance Standards

MCO	Network Validation Rating for 2023
FMHP	Moderate Confidence
MMM	Moderate Confidence
PSM	Moderate Confidence
Triple-S	Moderate Confidence

Results of Validation Findings

The table below presents the validation rating with the comments when the rates was not deemed high confidence.

FMHP

Network Adequacy Indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Provider-to-Enrollee Ratios	☒Addressed ☐Missing	☒High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	
Provider Per Municipality Requirements	☒Addressed ☐Missing	☒High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	
Required Network Provider Facilities	☒Addressed ☐Missing	☐High confidence ☒Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	The contract states the specific facilities and, in some instances, the number of the facilities that must be contracted by the FMHP. FMHP and its contractor, APS, were not consistent with the responses of the definition of available facilities.

Network Adequacy Indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance Standards	☒Addressed ☐Missing	☐High confidence ☒Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	The addresses for beneficiaries and providers may not always be recognized as valid. In these circumstances the zip code is used to approximate a location. Although this is a known limitation, FMHP cannot determine how far the estimated address used to calculate distance is from the actual address for both provider and member.

Recommendations to Improve MCO Assessment of Network Adequacy

The table below includes high level recommendations for FMHP to enhance its data collection, report development and use of the information to improve members access to care using network if providers.

CY 2023 was the first year when this assessment was performed; therefore, there are no recommendations from the prior years.

Managed Care Plan (MCP) name: FMHP
Prior Recommendation Year (if applicable): N/A.
EQRO Prior Recommendations (if applicable): N/A.
Summary of MCP Response to Prior Recommendations (if applicable): N/A.
EQRO Assessment of Degree to which MCP Effectively Addressed the Recommendations (if applicable): N/A.
Current Recommendation Year: CY 2023.
EQRO Current Recommendations for MCP Assessment of Network Adequacy: FMHP should carefully review the addresses for providers and members used for the calculation of time and distance standards and identify opportunities for data enhancement. Additionally, FMHP could benefit from comprehensive understanding of

Managed Care Plan (MCP) name: FMHP
how the distance is calculated using the software to further increase the meaningful use of the results. FMHP should define the process on what constitutes available facilities and use external sources to confirm that, in fact, all available facilities are included in the calculation of the indicator.

MMM

Network Adequacy Indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Provider-to-Enrollee Ratios	☒Addressed ☐Missing	☒High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	
Provider Per Municipality Requirements	☒Addressed ☐Missing	☐High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	
Required Network Provider Facilities	☒Addressed ☐Missing	☒High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	

Network Adequacy Indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance Standards	☒Addressed ☐Missing	☐High confidence ☒Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	The addresses for beneficiaries and providers may not always be recognized as valid. In these circumstances, the zip code is used to approximate a location. Although this is a known limitation, MMM cannot determine how far the estimated address used to calculate distance is from the actual address for both provider and member.

Recommendations to Improve MCO Assessment of Network Adequacy

The table below includes high level recommendations for the MCO to enhance its data collection, report development and use of the information to improve members access to care using network if providers.

CY 2023 was the first year when this assessment was performed; therefore, there are no recommendations from the prior years.

Managed Care Plan (MCP) name: MMM
Prior Recommendation Year (if applicable): N/A.
EQRO Prior Recommendations (if applicable): N/A.
Summary of MCP Response to Prior Recommendations (if applicable): N/A.
EQRO Assessment of Degree to which MCP Effectively Addressed the Recommendations (if applicable): N/A.
Current Recommendation Year: CY 2023
EQRO Current Recommendations for MCP Assessment of Network Adequacy: MMM should carefully review the provider and member addresses used for the calculation of time and distance standards and identify opportunities for data enhancement. In the data submitted to EQRO approximately 70% of all the providers have the address as distributives vs. actual; similarly, over 60% of members addresses are mapped as zip distributive. For zip distributive, the assignment of the latitude/ longitude coordinate uses an algorithm, and the points are approximate and are not based upon the actual address.

PSM

Network Adequacy Indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Provider-to-Enrollee Ratios	☒Addressed ☐Missing	☒High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	
Provider Per Municipality Requirements	☒Addressed ☐Missing	☒High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	
Required Network Provider Facilities	☒Addressed ☐Missing	☐High confidence ☒Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	The contract states the specific facilities and, in some instances, the number of the facilities that must be contracted by PSM. PSM was not consistent with the responses of the definition of available facilities.

Network Adequacy Indicator	Did the MCP address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Time and Distance Standards	☒Addressed ☐Missing	☐High confidence ☒Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	The addresses for beneficiaries and providers may not always be recognized as valid. In these circumstances, the zip code is used to approximate a location. Although this is a known limitation, PSM cannot determine how far the estimated address used to calculate distance is from the actual address for both provider and member.

Recommendations to Improve MCO Assessment of Network Adequacy

The table below includes high level recommendations for the MCO to enhance its data collection, report development and use of the information to improve members access to care using network if providers.

CY 2023 was the first year when this assessment was performed; therefore, there are no recommendations from the prior years.

Managed Care Plan (MCP) Name: PSM
Prior Recommendation Year (if applicable): N/A.
EQRO Prior Recommendations (if applicable): N/A.
Summary of MCP Response to Prior Recommendations (if applicable): N/A.
EQRO Assessment of Degree to which MCP Effectively Addressed the Recommendations (if applicable): N/A.
Current Recommendation Year: 2023
EQRO Current Recommendations for MCP Assessment of Network Adequacy: PSM should carefully review the provider and member addresses used for the calculation of time and distance standards and identify opportunities for data enhancement. For zip distributive, the assignment of the latitude/ longitude coordinate uses an algorithm, and the points are approximate and are not based upon the actual address. PSM should define the process on what constitutes available facilities and use external sources to confirm that, in fact, all available facilities are included in the calculation of the indicator.

Triple-S

Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Provider-to-Enrollee Ratios	☒Addressed ☐Missing	☒High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	
Provider Per Municipality Requirements	☒Addressed ☐Missing	☒High confidence ☐Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	

Network Adequacy Indicator	Did the MCO address this indicator in its network adequacy monitoring activities?	Validation Rating	Comments
Required Network Provider Facilities	☒Addressed ☐Missing	☐High confidence ☒Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	The contract states the specific facilities and, in some instances, the number of the facilities that must be contracted by Triple-S. Triple-S was not consistent with the responses of the definition of available facilities.
Time and Distance Standards	☒Addressed ☐Missing	☐High confidence ☒Moderate confidence ☐Low confidence ☐No confidence ☐Could not be validated	The addresses for beneficiaries and providers may not always be recognized as valid. In these circumstances, the zip code is used to approximate a location. Although this is a known limitation, Triple-S cannot determine how far the estimated address used to calculate distance is from the actual address for both provider and member.

Recommendations to Improve MCO Assessment of Network Adequacy

The table below includes high level recommendations for the MCO to enhance its data collection, report development and use of the information to improve members access to care using network if providers.

CY 2023 was the first year when this assessment was performed; therefore, there are no recommendations from the prior years.

Managed Care Plan (MCP) name: Triple-S
Prior Recommendation Year (if applicable): N/A.
EQRO Prior Recommendations (if applicable): N/A.
Summary of MCP Response to Prior Recommendations (if applicable): N/A.
EQRO Assessment of Degree to which MCP Effectively Addressed the Recommendations (if applicable): N/A.
Current Recommendation Year: 2023
EQRO Current Recommendations for MCP Assessment of Network Adequacy: Triple-S should carefully review the provider and member addresses used for the calculation of time and distance standards and identify opportunities for data enhancement. For zip distributive, the assignment of the latitude/ longitude coordinate uses an algorithm, and the points are approximate and are not based upon the actual address. Triple-S should define the process on what constitutes available facilities and use external sources to confirm that, in fact, all available facilities are included in the calculation of the indicator.

Appendix A

Review of Compliance with Medicaid Managed Care Regulations for MCOs

Introduction

To complete the CAP review of compliance with Medicaid managed care regulations, Mercer utilized the mandatory compliance validation protocol (Protocol 3) to determine the extent to which MCOs comply with federal standards set forth in 42 CFR 438, part 56, 100, 114, Subparts D and Quality Assessment and Performance Improvement (QAPI), State standards, and MCO contract requirements. Below is a crosswalk of the standards reviewed by the EQRO.

Standard Reviewed by the EQRO	Subpart D and QAPI Standard
Enrollee Rights and Protections	§438.56 Disenrollment Requirements and Limitations
	§438.100 Enrollee Rights Requirements
Provider Network	§438.206 Availability of Services
	§438.207 Assurances of Adequate Capacity of Services
	§438.214 Provider Selection
	§438.230 Sub-contractual Relationships and Delegation
Care Management	§438.208 Coordination and Continuity of Care
	§438.224 Confidentiality
Utilization Management (UM)	§438.210 Coverage and Authorization of Services
	§438.114 Emergency and Post-stabilization Services
	§438.236 Practice Guidelines
Grievance and Appeals (G&A)	§438.228 Grievance and Appeal Systems
Quality Improvement and Assessment	§438.242 Health Information Systems
	§438.330 QAPI

FMHP

Administration and Organization

Process and Documentation Reviewed

Mercer conducted a desk review of submitted documentation as well as a virtual on-site meeting held June 24, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Operational Director of Regulatory Affairs
- Business Intelligence Director
- IT Director
- Director of Corporate Compliance
- Regulatory Affairs VP and Privacy Officer
- Senior Development Director

Organizational Structure

FMHP was formed in 1977 under the laws of the Commonwealth of Puerto Rico. First Medical (FM) Salud is also organized under the laws of the Government of Puerto Rico and was hired by FMHP in 2014 as a delegated entity for numerous responsibilities.

FMHP's corporate structure is governed by a Board of Directors composed of seven members and a chairperson, and an executive team responsible for managing administrative policies and decisions. The FMHP president works closely with the Board of Directors to set goals, plans, and strategies and has oversight of FM Salud. (an affiliated entity responsible for delegated tasks). The FM Salud VP and Director positions report to the Administrative President for the Plan Vital line of business. The Senior VP of Administration for FMHP reports to the President and has oversight of the VP and Director positions. The CMO is responsible for providing medical leadership, strategic guidance, and oversight of clinical and medical affairs. The CMO is effective in the role since April 24, 2023, having previously served as VP of Medical Affairs. There were no other significant changes in department and reporting structure. Both FMHP and FM Salud are located in Puerto Rico. FMHP offers Medicaid and Commercial LOBs. The commercial segment includes Government of Puerto Rico employees, private enterprise, and individual plans.

FMHP currently has approximately 700 employees in total. Of these, 333 are solely dedicated to Plan Vital and 71 work for both LOBs. FMHP offers two service centers and 17 service offices throughout Puerto Rico, serving approximately 500,000 members. The service centers (call centers) and service offices (walk in) offer customer service to Enrollees including issuing ID cards and certificates of coverage, changing an Enrollee's PMG or PCP, managing pre authorizations, explaining benefits, completing HIPAA authorized designation forms, providing orientation to the grievance and appeal process, and assisting with claims

and payment status. The service centers operate Monday through Friday from 7:00 am to 7:00 pm and the service offices typically operate Monday through Friday from 8:00 am to 5:00 pm but have Saturday hours and extended evening hours as per contractual requirements.

Delegated Entities

FMHP delegates responsibilities to seven different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico	Mental Health (MH) — MH benefits, MH provider network credentialing and re-credentialing, MH claims processing and payment, pharmacy services, MH quality and UM services, MH Clinical programs, Behavioral Health (BH) Care Management (CM), BH prescription prior authorizations, MH and pharmacy G&A, MH education, reporting, and MH Enrollee and provider call center.
Alpine Technologies	Information Management and Information Systems processes such as maintenance of information integrity, system security, systems availability, and monitoring of critical systems.
InHealth Management LLC.	Hospital UM including evaluation of clinical appropriateness, type and volume of services, hospital review appeals, addressing over, under and inappropriate utilization and development of hospital UM reports.
IVision	Maintenance of vision claims management system, including processing, adjudications, and payment of claims and payment reports. Credentialing and re-credentialing of vision providers.
First Health Call Corporation	Responsible for provider call center and GHP service line including operations and monitoring of the automated call distribution system of GHP Information Service, compliance with call center standards, post discharge monitoring, Health Risk Assessment, and other services.
FM Salud	Network administration including adequacy maintenance, contracting, credentialing and re-credentialing, provider education, enrollment, claims processing, G&A, medical services, case

Delegated Entity	Type of Entity and Services
	management, quality and management of medical groups and human resources.
Net Claims	Maintenance of dental claims management system and claims payment administrative functions such as timely processing, adjudication and payment of claims and claims payment reports.

FMHP has P&Ps in place operationalizing the auditing, oversight, and monitoring of delegated entities. These policies describe audit and corrective action procedures, protection of Protected Health Information (PHI) and requirements pertaining to sub-delegation. FMHP's Compliance Audit and Monitoring Department is responsible for the evaluation of any subcontractor. The department includes a director, three compliance specialists and a compliance coordinator. The main functions include but are not limited to:

- Oversight of the subcontractor's compliance with the delegated functions as outlined in their contract.
- Performance monitoring on an ongoing basis and formal review as scheduled.
- Identifying deficiencies or areas of improvement to promote action plans for identified findings.

Accreditation

Accreditation is not a contract requirement; however, several delegates have accreditation. APS currently has Utilization Review Accreditation Commission (URAC) Health Plan Accreditation through September 1, 2025. FM Salud holds NCQA CVO accreditation though 2026, Net Claims solution holds Electronic Healthcare Network Accreditation Commission, Eligibility and Benefits CORE Certification Seal, Claims Status CORE, and Certification Clearinghouse Seal. First Health Call also has URAC accreditation as a Health Call Center through July 1, 2025.

Employee Training

All FMHP employees are enrolled in a "Welcome On-Board Program" to ensure they complete all regulatory trainings, understand ASES contractual requirements and FMHP P&P's. Employees are given an account in an e-learning platform where new hire and annual regulatory trainings include Compliance, Code of Conduct, Fraud, Waste, and Abuse (FWA), Cultural Competency, HIPAA, QAPI, Medicaid Overview, Grievances, and Advance Directives. The onboarding program is completed within 90 days of hire. Delegated entities and subcontractor staff are also required to complete the majority of these trainings. All employees are subject to a proficiency test after the trainings with an 85% passing rate. Employees also participate in trainings specific to their area of hire. At least annually, FMHP evaluates the changes in regulations and contractual requirements to determine if new trainings need to be developed or current trainings revised and updated. The FMHP

Organizational Development Unit is responsible for maintaining documentation related to training material, attendance and test results for at least 10 years.

Enrollee Rights and Protections

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MCO complies with the state enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MCO has written policies related to Enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable State and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MCO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MCO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under state law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the state laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through a virtual on-site review held on June 24, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Director of Corporate Compliance
- Compliance Officer
- Senior VP of Clinical Affairs

Overall Assessment

For Enrollee Services, FMHP had four open CAP items from 2022. Three of these CAP items were closed in 2023 as FMHP updated the associated P&Ps in 2023, meeting the metric's requirements.

FMHP had one open CAP item from 2022 pertaining to processes for providers to follow when a provider issues a moral and religious objection resulting in a refusal to provide, reimburse or not provide a referral or prior authorization based on an objection of this type. As part of the desk review process, FMHP submitted their Standard Operation Procedure (SOP) – Provider Conscience Objections (revised 12/2023) which provides guidance to providers regarding religious and moral objections. The guidance states that providers must notify both ASES and Enrollees of their decision not to provide the service. FMHP also submitted updated provider guidelines which indicates this same information and notifies providers of the timelines in which these notifications should occur before adoption of the policy with respect to any service (120 calendar days for ASES and within 90 calendar days for Enrollees). FMHP received approval from ASES of these changes to the SOP and provider guidelines on February 6, 2024, and the documents were released to the providers on February 15, 2024. Since the release of the SOP and provider guidelines and the associated training occurred in 2024, the CAP will remain unchanged from 2023.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Enrollee Rights and Protections	4	3	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that reflect an Enrollee may request disenrollment from the MCO without cause once during the applicable Open Enrollment Period (5.2.5, Amendment A). ASES may require an Enrollee seek redress through the MCO's grievance system before ASES makes a determination on the Enrollee's request for disenrollment (5.3.5.8). (42 CFR § 438.56(d)(5)) The MCO will adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made in accordance with (5.3.3.3-5.3.5).	Partially Met	Met	All requirements of this metric have been met through RFI document and other submissions. Outstanding questions were clarified during the virtual on-site presentation.	None

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that comply with: written at a fourth grade reading level in English and Spanish; provided to Enrollees 18 years of age and older; (7.10.1) advise Enrollees of their rights under the laws of Puerto Rico to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; the implementation of those rights, including a statement of any limitation regarding implementation of Advance Directives as a matter of conscience; and the Enrollee's right to file complaint or grievance concerning noncompliance with Advance Directive requirements directly with ASES or with the Puerto Rico Office of the Patient Advocate. (14.9) The P&Ps reflect a description of Puerto Rico law and requires the MCO to reflect changes in laws as soon as possible and no later than 90 calendar days after the effective change (7.10). (42 CFR § 438.3(j)), 42 CFR 422.128(a), 42 CFR.128(b), 42 CFR 489.102(a), and Law No. 160 of November 17, 2001.	Partially Met	Met	All requirements of this metric have been met through RFI document and other submissions. Outstanding questions were clarified during the virtual on-site presentation.	None

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that describe the use of any moral or religious objections to cover, reimburse, refer, or prior authorization any service with the scope of the detailed covered services. The P&Ps include notification to ASES, Enrollees and potential Enrollees as provided in 7.13.1 of the contract (42 CFR § 438.102(b) and 42 CFR § 438.10(g)(2)(ii) (A and B)). The MCO has P&Ps that permit the Enrollee to change PCP due to moral or religious conflict. (5.4.1.5.1)	Not Met	Not Met	During the desk and virtual on-site review, FMHP shared supporting documents and evidence which operationalized this standard across all provider-interfacing units within the organization in 2024. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Continue all planned and active CAP activities in 2024 to reach compliance for this CAP item, including but not limited to evidence that staff have been trained on all changes. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy will require completion during CY 2024 for submission.
The MCO has P&Ps that require the MCO to provide Enrollees at least 30 calendar days written notice of any significant change in policies concerning Enrollee disenrollment rights, right to change Primary Medical Groups (PMGs) or Primary Care Physician (PCPs), or items listed as Enrollee rights and responsibilities in 6.5 of the contract. (6.1.6) (42 CFR § 438.10(g)(4)).	Not Met	Met	All requirements of this metric have been met through RFI document and other submissions. Outstanding questions were clarified during the virtual on-site presentation.	None

Provider Network

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and re-credentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MCO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with State requirements. The MCO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MCO has P&Ps in place which guarantee the MCO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MCO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MCO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To meet the requirements for the CAP review, FMHP submitted documentation such as trainings, new P&Ps, and the annual network development and management plan as well as targeted responses to the outstanding finding from the 2023 comprehensive review. In addition, FMHP presented a detailed presentation in response to each request within the RFI provider network section. This review was conducted based on information submitted by the MCO through the RFI and through a virtual on-site meeting held June 24, 2024. This meeting involved participation from MCO key leadership including, but not limited to:

- Contract and Provider Service Director
- Operations Director
- VP of Operations
- Operations Director
- Credentialing Department Director
- VP of Regulatory Affairs
- Corporate Compliance Director
- Compliance & Quality Director
- Regulatory Reports Unit Supervisor

Overall Assessment

FMHP reported that there are no significant changes in the provider network since the CY 2023 comprehensive EQR and provided a side-by-side comparison of the network from 2022 to 2023 as well as described current network challenges. There remain areas where the network standards are not met, mostly due to providers not available in specific locations. FMHP confirmed that at least annually, network exceptions are submitted and approved by ASES. The team has a focus on continual quality improvement for the provider network. A few examples include use of alternative payment models (APMs) and engagement with graduating physicians from medical schools to orient the process of Medicaid enrollment, contracting and credentialing, and to contract with new physicians as soon as possible. This process is also in place for psychiatrists through APS.

To meet the requirements for the CAP review, Mercer requested follow up documentation regarding the P&Ps for provider termination that needed to be revised in order to be in compliance. FMHP had clear provider termination process documentation however lacked inclusion of the requirement for submission of reports to ASES when no action is taken against providers. FMHP provided documentation which verified that FMHP has a process to track and submit regulatory reports as required and has a process to monitor these reports with submissions. As this P&P and process was in place in 2023, this CAP item has been closed as it is met.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Provider Network	1	1	0

The following subcontractors support Provider Network functions:

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico	BH network management activities, including contracting, credentialing and re-credentialing.
FM Salud, Inc. also known as International Medical Card (IMC)	Network Administration including adequacy maintenance, credentialing and re-credentialing processes and educational program to provider.
IVision	Contracting, credentialing, and re-credentialing of vision providers.

The table below outlines an overview of the MCO network.

Provider Type	Number of Providers in CY 2023
Primary Care Physician (PCP) (total)	3,735
Adult	1,779
Pediatric	1,956
Primary Medical Groups (PMG)	113
Obstetrics and Gynecology (OB/GYN) Providers	283
Hospital	55
FQHC	16
Urgent care	105
Nursing facility	1
Adult and Pediatric Dental Providers	558
Vision	296

Provider Type	Number of Providers in CY 2023
Adult High Volume Specialty Care Providers (total)	617
Cardiology	217
Endocrinology	76
Oncology	123
Nephrology	109
Pulmonology	92
Pediatric High Volume Specialty Care Providers (total)	236
Cardiology	10
Endocrinology	10
Oncology	15
Pulmonology	14
Speech, Language and Hearing	187
Psychiatric Hospitals	13
Psychiatric Partial Hospitals	34
Adult and Pediatric Mental Health Providers (Psychologist, Psychiatrist, Licensed Clinical Social Worker and/or Licensed Professional Counselor)	1,016
Substance Use Disorder (SUD) Inpatient Detoxification and/or rehabilitation	17
SUD Intensive Outpatient (IOP) and/or partial hospitalization provider (PHP)	40
Addiction medicine/withdrawal management provider	41

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCOs have written P&Ps for provider termination that comply with 10.4 and reporting of provider terminations and suspensions. (18.2.5.4)	Partially Met	Met	All requirements of this metric have been met through RFI document and other submissions. Outstanding questions were clarified during the virtual on-site presentation.	None.

Care Management

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MCO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 24, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- VP of Regulatory Affairs
- Senior Medical Director
- Operations Director of Regulatory Affairs
- Managed Care Director
- VP of Medical Affairs, APS
- UM Director, APS

Overall Assessment

The CY 2022 EQR identified two findings that required a CAP within the Care Management requirements for FMHP. The first item pertains to 42 CFR § 438.208(b)(2) regarding coordination of care that actively links the Enrollee to providers, medical services, residential, social, and other support services. To facilitate care and coordination of services, the MCO contract article 7.1.6 requires FMHP to cover the availability of health care services through telehealth, telemedicine, and teledentistry. During the CY 2022 review, Mercer learned that FMHP contracts with a vendor, TeleMedik, to perform telemedicine services. However, Mercer was unable to find policy language illustrating the provision of teledentistry services.

In response to the CAP, FMHP revised the Care Management Program Description to state that teledentistry education material will be provided in the Enrollee Manual and Enrollees Bulletin among others. However, FMHP has not revised or develop P&Ps to include the availability of services through teledentistry to include, but not limited to, use of teledentistry codes, teledentistry modalities, Enrollee consent, record keeping, confidentiality of the Enrollee 's health information as required by the HIPAA, and documentation.

The second CAP item pertains to demonstrating processes and strategies to collaborate with intergovernmental agencies, achieve an 85% enrollment rate for both pregnant and non-pregnant members, community outreach, wellness promotion, engaging providers, and targeting and tailoring programs to the different levels of physical and/or behavioral healthcare needs. During the CY 2022 review, Mercer unable to find policy language demonstrating engagement strategies for members living in remote areas as required by the MCO contract article 12.6.1.1.

As a result, FMHP has updated the Wellness Plan to include conducting community outreach initiatives to those Enrollees living in remote areas. However, the Wellness Plan does not specify remote-area specific targeted strategies including, but not limited to, targeted goals, methodology, and targeted dates for engaging Enrollees.

Out of two (2) CAP items identified, two (2) CAPs remain open as outstanding items.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Care Management	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps on: Coordination of care that actively links the Enrollee to providers, medical services, residential, social, and other support services, including coordination of care between MCOs, settings of care and discharge planning for short and long-term hospital and institutional stays, and from community and social support providers. The availability of healthcare services through telehealth, telemedicine, and teledentistry. (42 CFR § 438.208(b)(2)) (7.8.2.3.7) (7.1.6 Amendment M)	Partially Met	Partially Met	FMHP did not update P&Ps to include teledentistry but has shared information on the availability of teledentistry with providers via normative letters from ASES via FMHP website and emails to providers. CAP will remain unchanged in the CY 2023 findings.	Policy development or revision to include the ability to access services through teledentistry. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), provide revised P&Ps, all training and education provided to staff, providers, and Enrollees related to the implementation of P&Ps, oversight, and monitoring of implementation.
The MCO's Wellness Plan includes: A strategy for coordination with government agencies of Puerto Rico integral to disease prevention efforts and education efforts, including the Health	Partially Met	Partially Met	FMHP as revised the Wellness Plan to clarify that health-related community service strategies include those living in remote areas. However, the	Policy revision or development to address engagement of members living in remote areas. To gain compliance for the next EQRO review cycle,

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
Department, the Department of the Family, and the Department of Education. The MCO's Wellness Plan incorporates strategies to reach all Enrollees including those living in remote areas of the Contractor's Service Regions. Measurement strategy for reaching at minimum, 85% of GHP Enrollees. Strategy to ensure 85% of pregnant Enrollees receive services under the Pre-Natal and Maternal Program. Strategies for encouraging Enrollees to: Seek annual healthy checkup; appropriately use the services of the GHP, including GHP Service Line; Seek women's health screenings including mammograms, pap smears, cervical screenings, and test for sexually transmitted infections; Maintain a healthy body weight; seek an annual dental exam; Seek BH screening; Attend to the medical and developmental needs of children and adolescents; Receive education regarding the diagnosis and treatment of high-risk diagnosis including:			Wellness Plan does not include remote-area specific targeted strategies to engage with Enrollees. CAP will remain unchanged in the CY 2023 findings.	(CY 2024, which will be reviewed in 2025), provide revised P&Ps, all training and education provided to staff, providers, and Enrollees related to the implementation of P&Ps, oversight, and monitoring of implementation.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
Depression; Schizophrenia; Bipolar disorders; Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder; Substance abuse and Anxiety disorders. (7.5.8.2) (12.5.8.2) (12.6.1.2.1-9) (12.6.1.3)				

Utilization Management (UM)

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 24, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- UM Manager, FMHP
- UM Director, FMHP
- Regulatory Report Unit Supervisor, FMHP
- Transition Management Manager, FMHP
- Clinical Pharmacist, FMHP
- Pharmacy Director, FMHP
- Director of Corporate Compliance, FMHP
- UM Staff, APS

Overall Assessment

To address the requirements for the UM CAP review, FMHP submitted documentation such as policies and targeted and narrative responses to the outstanding findings from the 2022 review.

There were two topic areas where follow-up information was requested to meet the standards. Within the desk review submission, FMHP responded to each item, and this information, combined with the virtual review provided evidence of fully meeting the standard.

Additionally, FMHP described a training protocol for all employees and subcontractors that includes annual training on policies and procedures and training as needed when changes are implemented. New hire training is completed within 90 days of hire. Signatures are required to demonstrate learning and understanding of the content.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Utilization Management (UM)	2	2	0

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has written UM P&Ps to assist Enrollees and providers to ensure appropriate utilization of resources. The MCO's P&Ps reflect the subcomponents listed under 11.2.1 of the GHP contract. (42 CFR § 438.210(a)(3 and 4) and 42 CFR § 438.210(b))	Partially Met	Met	All requirements of this metric have been met through RFI document and other submissions. Outstanding questions were clarified during the virtual on-site presentation.	None
The MCO has written P&Ps that reflect that: (i) emergency services do not require a referral or prior authorization, no matter whether the Provider is within the PPN (11.4.6); (ii) the MCO covers post-stabilization services consistent with the requirements in 7.5.9.4 of the contract; and (iii) the Enrollee treated for an emergency medical condition or psychiatric emergency shall not be held liable for any subsequent screening or treatment necessary to stabilize the Enrollee. (7.5.9.4.2) (42 CFR § 438.114)	Partially Met	Met	All requirements of this metric have been met through RFI document and other submissions. Outstanding questions were clarified during the virtual on-site presentation.	None

Grievance and Appeals (G&A)

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MCO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all G&As filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of FMHP's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 24, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Regulatory Affairs VP and Privacy Officer
- Operational Director of Regulatory Affairs
- Director of G&A

Overall Assessment

The CY 2022 EQR identified two findings that required a CAP within the G&A requirements for FMHP. The first item pertains to 42 CFR § 438.402 and the MCO Contract articles 14.1.5 and details in 14.5.15 regarding an internal Grievance and Appeal System under which Enrollees, or providers acting on their behalf, may express dissatisfaction with the contractor or challenge the denial of coverage of, or payment for, Covered Services. FMHP is required to have P&Ps that include the process for filing a complaint. During the CY 2022 review, Mercer noted that only 11 complaints were received in a five-year period, and recommended to conduct an audit of Member Services calls to ensure that all complaints are captured and reported appropriately as well as provide training to member-facing staff on identifying complaints and grievances as needed based on audit findings.

In response to the CAP, FMHP performed a root cause analysis and determined that the calls were not being categorized correctly by Call Center and Regional Offices representatives. Subsequently, FMHP provided staff training in April 2024 and has seen an increase in the number of Complaints received by three to seven per day.

The second CAP item pertains to the Enrollee's ability to file an Appeal either orally or in writing per the MCO Contract articles 14.5.2 and 14.5.4. During the CY 2022 review, Mercer noted that FMHP's P&Ps contained requirements for the member to confirm verbal appeals in writing, which does not align with the contract. Subsequently, Mercer recommended FMHP to review and update P&Ps, the provider manual, and the MCO process flow chart to align with the contract and provide any necessary staff training and SOPs, related to changes made.

As a result, FMHP revised the Adverse Benefit Determinations letter on November 9, 2023, by eliminating the language that required the Enrollees to submit a written confirmation within 10-days for appeals filed verbally. During the virtual on-site review, FMHP shared with Mercer the revised 2024 Provider Manual with corrected information; however, as of the virtual on-site review date, FMHP's website has the 2023 Provider Manual with incorrect information. Also, FMHP did not provide any evidence of providing member education.

Out of two CAP items identified, two CAPs remain open as outstanding items.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Grievance and Appeals (G&A)	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO's Grievance System P&Ps includes: P&Ps, timelines for filing a complaint, grievance, or appeal, or seeking an ALH; process for receiving, recording, tracking, reviewing, reporting, and resolving complaints, grievances, and appeals filed verbally, in writing, or in-person; process for requesting an expedited review of an appeal; process for notifying Enrollees of their right to file a complaint, grievance, or appeal with the Patient Advocate Office and how to contact the Patient Advocate Office; Process for providing Enrollee available assistance in filing a grievance or appeal with the contractor. Process for written Notices of Adverse Benefit Determination to Enrollees must meet the language and for at requirements in section 6.2 and 6.3 and be set in accordance with the timeframes described in	Partially Met	Partially Met	FMHP performed a root cause analysis and determined that the calls were not being categorized correctly by Call Center and Regional Offices representatives. FMHP provided staff training in April 2024 and has seen an increase in member complaints. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Conduct an audit of member service calls received to ensure that all complaints are captured and reported appropriately and provide training to member-facing staff on identifying complaints and grievances as needed based on audit findings. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), continue to monitor staff compliance with correct categorization of Complaints and Service Requests and incorporate Complaints data as part of the overall Grievance and Appeals System to improve operational efficiencies and care

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
GHP section 14.4.4 and details in 14.5.15.(42 CFR § 438.402)				delivered to Enrollees.
The MCO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 calendar days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal. (42 CFR §438.402 (2)(ii)) (GHP 14.5.2, 14.5.4)	Partially Met	Partially Met	FMHP revised the Adverse Benefit Determinations letter on November 9, 2023, by eliminating the language that required the Enrollees to submit a written confirmation within 10-days for appeals filed verbally. Regarding provider education, FMHP has updated the Provider Guidelines in February 2024. However, as of the June 2024 virtual on-site review date, FMHP's website lists the outdated 2023 Provider Guidelines version. FMHP did not provide any evidence of providing member education. CAP will remain unchanged in the CY 2023 findings.	Review and revise member and provider materials to align with MCO policies, contract, and federal requirements. Provide revised letter template. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), the implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Quality Improvement and Assessment

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330 (b–e).

The intent of this regulation is to ensure the MCO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Findings

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Quality Improvement and Assessment	0	0	0

FMHP did not have CAP items in this area from the CY 2022 EQRO review.

MMM

Administration and Organization

Overview

Process and Documentation Reviewed

Mercer conducted a desk review of submitted documentation as well as a virtual on-site meeting held June 25, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- CMO
- Chief Operating Officer (COO)
- BH Program and Services Director
- Mental Health Medical Director
- Staff VP
- Wellness Manager
- Director of Health Care Management
- Compliance Manager
- Compliance Officer
- Compliance Specialist
- IT Support Services

Organizational Structure

MMM administers its GHP under MMM Multi Health, LLC, a subsidiary of MMM Holdings, LLC. MMM offers a GHP and Platino LOBs in Puerto Rico. MMM serves approximately 287,000 members under their GHP.

MMM's headquarters are located in Puerto Rico and operates 10 service centers located throughout Puerto Rico. The service centers work directly with beneficiaries to handle Enrollee material requests, assistance with completing G&A forms, submission of pre-authorization and case management documents, assistance with special coverage, coordination of pharmacy benefits, new enrollments, change of primary care physician (PCP) and Primary Medical Group (PMG) and other Enrollee-related needs. Service centers are typically open Monday through Friday from 8:00 am to 5:00 pm. Two service centers offer extended hours on Mondays until 7:00 pm and one center is open on one Saturday per month.

Since the last review, MMM has undergone some key leadership changes. The Chief Financial Offer (CFO) retired in December 2023 and his position has been filled. The Chief Marketing and Communications officer also left the company and was replaced in March 2024. There have been no organizational changes since the last review. MMM Healthcare, LLC operates under a corporate board of directors which oversees an executive leadership team. This executive leadership team is the same for all LOBs under MMM Holdings, LLC and includes a Compliance Officer, the COO, the CMO, the VP of Medicaid Operations, the VP of Quality Management (QM), and Five Stars Ops and legal counsel. Within MMM GHP, the VP of Medicaid Operations provides oversight of member services (including call centers and regional offices) and enrollment; the CMO oversees G&A. A related entity under MMM Holdings, LLC, the MSO of Puerto Rico, LLC (MSO), oversees clinical services, care management, UM, social work, and network management. Organization-wide, MMM employs over 3,000 employees that support their GHP, of which 359 are fully dedicated to the GHP.

Delegated Entities

In 2023, MMM delegated responsibilities to 12 entities as described in the table below. One entity, Insight, has been terminated in the review period and replaced with Carelon Global Solutions.

Delegated Entity	Type of Entity and Services
ATENTO	Beneficiary call center
InHealth Management	Hospital UM
Insight (terminated 10/31/23)	Provider call center for after-hours calls
INSPIRA	MH contracting and credentialing of MH providers
Ivision	Vision claims management
MSO of Puerto Rico, LLC (MSO)	UM, clinical services (physical and mental health), claims, pharmacy, Health Risk Assessment (HRA), contracting, credentialing and network management, audits and monitors contracted delegated entities
Net Claims Solution	Dental Services – Claims processing, direct members reimbursements, dental preservice platform
PMGs: PHM	Educational activities related to the Wellness program
PMGs: Redes del Sureste	Educational activities related to the Wellness program

Delegated Entity	Type of Entity and Services
PMGs: Alianza	Educational activities related to the Wellness program
Telemedik	PMG call center Medicaid
Carelon Global Solutions	Provider call center

MMM has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities and delegates these responsibilities to MSO. MMM provided evidence of similar P&Ps utilized by MSO for sub-delegates. MSO reports to MMM's dedicated unit, the Delegation Oversight Department, which is ultimately responsible for contract and regulatory oversight of delegated entities.

Accreditation

Although not a contractual requirement, MMM is pursuing a National Committee for Quality Assurance (NCQA) Health Equity accreditation with a proposed effective date of July 2024.

Employee Training

MMM has an established training program for new hires, subcontractors, and providers offered virtually or via an online educational platform. MMM requires new hire training within 90 days of hiring and requires either an exam or an attestation of completion. All subcontractors must present attestations as proof of completion. Staff and all delegates and subcontractors are trained in advance directives, cultural competency, FWA, HIPAA, BH, Enrollee rights, G&A, and Medicaid and covered Medicaid services. Training and education are also delivered at regularly scheduled meetings with delegated entities and through educational publications (bulletins and letters) to providers.

Enrollee Rights and Protections

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MCO complies with the state enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MCO has written P&Ps related to Enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable state and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MCO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MCO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (i).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under state law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the state laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 25, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Compliance Specialist
- Compliance Officer
- Member Services Manager
- Medicaid Compliance Officer
- Medicaid Chief Operating Officer
- Enrollment Manager

Overall Assessment

For Enrollee services, MMM had three open CAP items in 2022. The first CAP pertains to the adjustment of effective disenrollment dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when diagnosed with a terminal diagnosis. During the virtual on-site review, MMM provided evidence of an amended P&P (Disenrollments/Cancellations – revised on 06/26/2024) indicating their processes to adjust these disenrollment dates. Since the policy was amended and became effective in 2024, the CAP will remain unchanged in the 2023 findings.

The second open CAP item pertains to moral and religious objections issued by providers which result in a refusal to cover, reimburse, refer, or prior authorization of any service with the scope of the detailed covered services. MMM submitted an updated P&P which outlines the processes providers must follow when issuing this type of objection and the timelines providers are required to follow when notifying ASES and members. The plan also shared updated provider guidelines reflecting these policy changes. MMM received approval from ASES in 2024 and distributed the updated provider guidelines in February 2024. Training was also provided to MMM employees in the first quarter of 2024 to ensure administrative operationalization of these changes. Since activities pertaining to this CAP item occurred in 2024, this CAP will also remain unchanged in the 2023 findings.

The third CAP item pertains to the requirement to notify Enrollees of significant changes to enrollment rights, the right to change PMGs or PCPs, other items listed as Enrollee rights and responsibilities in the contract within 30 days of changes being implemented. MMM provided an updated P&P (Notification of Changes in Policies and Procedures – revised on 02/27/2024) which includes this required timeline of 30 days. The policy became effective in 2024, and similar to the other CAP items, the CAP will remain unchanged in the CY 2023 findings.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Enrollee Rights and Protections	3	0	3

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that reflect an Enrollee may request disenrollment from the MCO without cause once during the applicable Open Enrollment Period (5.2.5, Amendment A). ASES may require an Enrollee seek redress through the MCO's grievance system before ASES makes a determination on the Enrollee's request for disenrollment (5.3.5.8). (42 CFR § 438.56(d)(5)) The MCO will adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when a terminal diagnosis was made in accordance with (5.3.3.3-5.3.5.)	Not Met	Not Met	During the virtual on-site review, MMM submitted an updated P&P (Disenrollments/Cancellations – revised on 06/26/2024) which addresses how the plan will adjust disenrollment effective dates for Enrollees who are either hospitalized, pregnant, in the appeal process and/or within a month when diagnosed with a terminal diagnosis. CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	Continue all planned and active CAP activities in 2024 to reach compliance for this CAP item. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy will require completion during CY 2024 for submission.
The MCO has P&Ps that describe the use of any moral or religious objections to cover, reimburse, refer, or prior authorization any service with the scope of the detailed covered services. The P&Ps include notification to ASES,	Not Met	Not Met	MMM submitted an updated policy, Moral and Religious Objections Policy HSIP-GHP-024 (dated 02/24/2024) which clearly outlines the procedures and timelines providers must follow. MMM also submitted updated	Continue all planned and active CAP activities in 2024 to reach compliance for this CAP item. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
Enrollees and potential Enrollees as provided in 7.13.1 of the contract. (42 CFR § 438.102(b) and 42 CFR § 438.10(g)(2)(ii)(A and B)) The MCO has P&Ps that permit the Enrollee to change PCP due to moral or religious conflict. (5.4.1.5.1)			provider guidelines, evidence of provider notification of the changes, and evidence of employee training pertaining to the changes. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	implementation and monitoring of the policy will require completion during CY 2024 for submission.
The MCO has P&Ps that require the MCO to provide Enrollees at least 30 calendar days written notice of any significant change in P&Ps concerning Enrollee disenrollment rights, right to change PMGs or PCPs, or items listed as Enrollee rights and responsibilities in 6.5 of the contract (6.1.6) (42 CFR § 438.10(g)(4)).	Not Met	Not Met	MMM submitted a revised P&P, Notification of Changes in Policies and Procedures – revised on 02/27/2024, that includes language stating that changes to the disenrollment letter must be approved by ASES and notified to members at least 30 days before changes are implemented. CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	Continue all planned and active CAP activities in 2024 to reach compliance for this CAP item. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy will require completion during CY 2024 for submission.

Provider Network

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and re-credentialing of providers. Regulation 438.214 (c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214 (d) prohibits the MCO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with state requirements. The MCO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MCO has P&Ps in place which guarantee the MCO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MCO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MCO obtains state approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To meet the requirements for the CAP review, MMM submitted documentation such as trainings, new P&Ps, and the annual network development and management plan as well as targeted responses to the outstanding finding from the 2023 comprehensive review. This review was conducted based on information submitted by the MCO through the RFI and through a virtual on-site meeting held June 25, 2024. This meeting involved participation from MCO key leadership including, but not limited to:

- Senior Compliance Consultant
- PNO Supervisor
- Associate Vice President (AVP) of Contracting
- Network Management Director
- Chief Financial Officer, MSO
- Mental Health Regional Director

Overall Assessment

MMM reported that there are no significant changes in the provider network since the CY 2023 comprehensive EQR. They have a stable team of existing providers and use telehealth services in areas where there would otherwise be gaps in access. The providers have the tools needed to facilitate telehealth. MMM reports that the ongoing network challenges include access and availability for Culebra and Vieques and for pediatric sub-specialties.

As part of the CAP review process, Mercer requested follow up revisions for P&Ps on the provider termination process. MMM had clear provider termination process documentation however lacked inclusion of the requirement for submission of provider termination information to ASES within two business days prior to taking action due to violations to the Medicaid Integrity Program. MMM provided documentation which verified that MMM has a process to submit this report to ASES and to track all provider terminations. The compliance department submits the reports to ASES and providers the oversight. This policy was submitted through the RFI and was implemented February 14, 2024. As the implementation for this policy took place in 2024, the CAP item will remain open.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Provider Network	1	0	1

The following subcontractors support Provider Network functions:

Delegated Entity	Type of Entity and Services
MSO of Puerto Rico, LLC (MSO)	Provider contracting and credentialing, network adequacy. MSO may also subcontract to other entities.

The following table outlines the subcontractors that support MSO Provider Network functions.

Delegated Entity	Type of Entity and Services
Inspira Behavioral Care Corporation	Network functions, including contracting, credentialing and re-credentialing of MH providers.
Ivision Contracting	Network functions, including contracting, credentialing and re-credentialing of vision care providers.

The table below outlines an overview of the MCO network.

Provider Type	Number of Providers in CY 2023
Primary Care Physician (PCP) (total)	
Adult	1,553
Pediatric	1,781
Primary Medical Groups (PMG)	99
Obstetrics and Gynecology (OB/GYN) Providers	447
Hospital	46
FQHC	61
Urgent Care	100
Nursing Facility	4
Adult and Pediatric Dental Providers	977
Vision	425
Adult High Volume Specialty Care Providers (total)	
Cardiology	272
Endocrinology	112
Oncology	162
Nephrology	186
Pulmonology	135
Pediatric High Volume Specialty Care Providers (total)	
Cardiology	7
Endocrinology	6
Oncology	9
Pulmonology	14

Provider Type	Number of Providers in CY 2023
Speech, Language and Hearing	183
Psychiatric Hospitals	13
Psychiatric Partial Hospitals	35
Adult and Pediatric Mental Health Providers (Psychologist, Psychiatrist, Licensed Clinical Social Worker and/or Licensed Professional Counselor)	887
SUD Inpatient Detoxification and/or Rehabilitation	41
SUD Intensive Outpatient (IOP) and/or Partial Hospitalization Provider (PHP)	41
Addiction Medicine/Withdrawal Management Provider	211

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCOs have written P&P for provider termination that comply with 10.4 and reporting of provider terminations and suspensions. (18.2.5.4)	Partially Met	Partially Met	The Provider Termination policy was updated on February 14, 2024, to include generating the report that will be used to monitor timeframes related to provider termination, timeframes for notifying ASES and generating the required report. This updated policy was submitted in response to the RFI.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy will require completion during CY 2024 for submission.

Care Management

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MCO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held June 25, 2024. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Compliance Consultant Senior
- Associate Director
- Care Management Manager
- MH Medical Director
- Director of BH Program Service
- Preauthorization Manager
- UM Director
- Chief Clinical Operations Officer

- Wellness Manager
- Staff VP of Total Health Services
- Discharge Planner Manager
- Director
- Compliance Manager

Overall Assessment

The CY 2022 EQR identified three findings that required a CAP within the Care Management requirements for MMM. The first item pertains to how Enrollees can access continued services pursuant to the transition of care process as specified in 42 CFR §438.208 and §438.62 and the MCO contract article 6.1.8. During the CY 2022 review, Mercer was unable to find language describing how Enrollees can access continued services for the transition of care process and recommended MMM revise language in the Beneficiary Manual to ensure that members can access that information.

In response to the CAP, MMM submitted a proposed revision to the Beneficiary Manual on February 29, 2024, to ASES, pending approval. During the virtual on-site review, Mercer reviewed the proposed language with MMM staff and advised that the language does not specify that an Enrollee transitioning from another contractor has access to services consistent with what they previously had, and that the Enrollee is permitted to retain their current provider for 90 calendar days if that provider is not a network provider. It is recommended that MMM further enhance the language to include more comprehensive information about the transition of care process.

The second CAP item is regarding actively linking the Enrollees to providers, medical services, residential, social, and other support services. In this effort, the Model contract article 7.1.6 requires the contractor to provide health care services through telehealth, telemedicine, and teledentistry. During the CY 2022 review, MMM provided P&Ps that addressed the use of telehealth and telemedicine in MH and substance use programs, however, Mercer was unable to find details regarding the use of telehealth and telemedicine for physical health supports, or language addressing the use of teledentistry. As a result, Mercer recommended MMM revise or develop P&Ps that describes the availability of telehealth and telemedicine for physical health services and addresses the availability of teledentistry services.

In response to the CAP, MMM developed P&Ps for telemedicine/teledentistry, on February 20, 2024. Per MMM staff, it consulted providers during the policy development phase to learn about what type of telehealth modality was being performed to include accurate information. MMM staff also informed that the Network Department has shared the policy and billing instruction via email with providers.

The final CAP item regards developing, monitoring, and routinely updating a treatment plan for each Enrollee who is registered for Special Coverage and identified as High-Cost High Needs (HCHN) Program. During the CY 2022 on-site review, Mercer noted while MMM has demonstrated compliance with the Special Coverage requirements, Mercer was unable to

locate language in P&P providing guidance on support of beneficiaries that are eligible for both Special Coverage and HCHN, or the treatment planning requirements when Enrollees qualify for both programs. As a result, Mercer commended MMM to revise or develop P&Ps that provides processes in the event an Enrollee qualifies for both Special Coverage and HCHN program, including where the treatment plan is developed under the HCHN program and complies with Special Coverage provisions.

The HCHN Program is no longer required per the MCO contract. Therefore, the CAP for this item has been closed.

Out of three CAP items identified, MMM closed out one CAP and two CAPs remain open as outstanding items.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Care Management	3	1	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that provide: Details and support of an ongoing source of care for Enrollees appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The process for the MCO to provide information to the Enrollee on how to contact their designated person or entity. Coordination efforts P&Ps shall include consultation with Enrollee's PCP.	Partially Met	Partially Met	Revised language does not explain what a transition of care process entails. Per the contract, section 5.5, the contractor must ensure that an Enrollee transitioning from one contractor to another has access to services consistent with the access they previously had, and the Enrollee is permitted to retain their current provider for 90 calendar days if that provider is not a network provider. The contractor is also required to refer	Revise language in the Beneficiary Manual to ensure that members have information regarding how to access continued services pursuant to the transition of care process. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), the implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
Instructions to Enrollees and Potential Enrollees in the Enrollee Handbook and notices approved by ASES on how to access continued services pursuant to its transition of care process (42 CFR § 438.208) (7.8.2.5) (7.8.2.4.6) (42 CFR § 438.62) (6.1.8) (Amendment A)			Enrollee to appropriate network providers to ensure continuity of care.	
The MCO has P&Ps on: Coordination of care that actively links the Enrollee to providers, medical services, residential, social, and other support services, including coordination of care between MCOs, settings of care and discharge planning for short and long-term hospital and institutional stays, and from community and social support providers. The availability of health care services through telehealth, telemedicine, and teledentistry. (42 CFR § 438.208(b)(2)) (7.8.2.3.7) (7.1.6 Amendment M)	Partially Met	Partially Met	MMM developed P&Ps, telemedicine/ teledentistry, on February 20, 2024. Per MMM staff, it consulted providers during the policy development phase to learn about what type of telehealth modality was being performed to include correct information. MMM staff also informed that the Network Department has shared the policy and billing instruction via email with providers. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Revise P&Ps to include comprehensive information on the availability of telehealth modalities for telemedicine and teledentistry, provider billing information, and prior authorization requirements. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), the implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that include: Treatment plans be developed by the Enrollee's PCP, with the Enrollee's participation, and in consultation with, any specialists caring for the Enrollee. Treatment plans and are reviewed and revised at least every 12 months, when needs change significantly, or at the request of the Enrollee; and include treatment plan elements as described in 7.8.2.4 of the MCO contract. Processes in the event an Enrollee qualifies for both Special Coverage and the HCHN Program, where the treatment plan developed under the HCHN program must comply with the Special Coverage provisions. (42 CFR § 438.208(c)) (7.7.8) (7.7.8.1)	Partially Met	Met	All requirements for these metrics have been met through RFI documents, virtual on-site discussions, and post virtual on-site submissions.	None

Utilization Management (UM)

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 25, 2024.The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Medicaid Compliance Officer
- Medicaid COO
- MH Medical Director
- Compliance Manager
- Compliance Specialist
- Staff VP of Total Healthcare
- Wellness Manager
- Director of Health Care Management
- BH Program and Service Director
- IT Support Services

Overall Assessment

To address the requirements for the UM CAP review, MMM submitted documentation of updated policies and verbal responses to the outstanding findings from the CY 2022 review.

There was one topic where follow-up information was requested to meet the standards. Within the desk review submission, MMM responded to the item, but it remained Partially Met, as MMM submitted changes but the final policies providing evidence of the changes occurred outside of the required 2023 timeframe.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Utilization Management (UM)	1	0	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has written UM P&Ps to assist Enrollees and providers to ensure appropriate utilization of resources. The MCO's P&Ps reflect the subcomponents listed under 11.2.1 of the GHP contract. (42 CFR § 438.210(a)(3 and 4) and 42 CFR § 438.210(b))	Partially Met	Partially Met	The CAP request was to develop or edit policies that outline MMM's process to ensure emphasis on relapse and crisis prevention. MMM revised the Policies BH-CM-01 Intensive Case Management and BH-CC-09 Emergency Services effective 02/29/2024. MMM described existing practices of meeting with the PMGs quarterly to ensure members, especially those with a chronic condition, have timely access to care. There is an initiative to reduce Emergency	The CAP will remain unchanged in the 2023 findings as the policy updates occurred in 2024. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), the implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
			Department visits by ensuring timely access to PMG appointments. For Enrollees that were inpatient, there is an expectation that they receive a follow up appointment within seven days. The Intensive Case Management program targets Enrollees with high-risk BH needs to address crisis and relapse prevention. Staff, including delegates, are trained annually and as needed to communicate and understand any policy change. Training completion is tracked, and delegates sign an attestation.	

Grievance and Appeals (G&A)

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MCO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all G&A filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual meetings held June 25, 2024. The virtual meetings involved participation from MCO key leadership including, but not limited to:

- Director of G&A
- Medicaid Compliance Manager
- Compliance Consultants

Overall Assessment

The CY 2022 EQR identified two findings that required a CAP within the G&A requirements for MMM. The first item pertains to the Enrollee's ability to file an appeal either orally or in writing per the MCO Contract articles 14.5.2 and 14.5.4. During the CY 2022 review, Mercer noted that MMM's P&Ps contained requirements for the member to confirm verbal appeals in writing, which does not align with the contract. Subsequently, Mercer recommended that MMM review and update P&Ps and member and provider materials to align with the contract.

In response to the CAP, MMM revised P&Ps, GA 005 Appeals, on February 2, 2024, and February 22, 2024, by incorporating the EQR recommendation to eliminate requirements for filing a written appeal within 10 business days following a verbal appeal. Also, MMM updated the Provider Guidelines and Beneficiary Manual in February 2024 and has submitted to ASES for review and approval. As of the CY 2023 virtual review date, approval is pending from ASES. During the CY 2023 virtual review, MMM staff informed Mercer that it has shared the revised P&Ps with G&A Department staff and verbally updated the Customer Service Department Manager. It is recommended that MMM share revised P&Ps and train with internal departments to include (but not limited to) the Customer Service Department to ensure that accurate information is communicated to Enrollees.

42 CFR §438.408(f) and the MCO contract article 14.6 require the contractor to explain the Enrollee's right to and the procedure for an Administrative Law Hearing (ALH), including that the Enrollee must exhaust the contractor's Grievance, Complaints, and Appeals process before requesting an ALH. During the CY 2022 review, Mercer noted that Enrollee and provider materials and MMM's P&Ps did not contain information about how and when an Enrollee can request an ALH.

In response to the CAP, MMM updated the Provider Guidelines and Beneficiary Manual in February 2024 by including information on how and when an Enrollee can file an ALH and has submitted guidelines to ASES for review and approval. As of the CY 2023 virtual review date, approval is pending from ASES. MMM staff reported that although both the Provider Guidelines and Beneficiary Manuals were recently updated, the member resolution letter contains required information on how and when an Enrollee can file an ALH. As evidence, MMM has provided the resolution letter in Spanish as part of the RFI. Subsequently, Mercer requested the English language version, reviewed during the virtual on-site review, and determined that the English version is missing a sentence contained in the Spanish language

version. It is recommended that MMM reviews the Enrollee resolution letter in the English version to ensure it contains complete information.

Of two CAP items identified, two CAPs remain open as outstanding items.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Grievance and Appeals (G&A)	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 calendar days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal within 10 calendar days. (42 CFR §438.402 (2)(ii)) (GHP 14.3.3, 14.5.2, 14.5.4)	Not Met	Not Met	MMM revised P&Ps, GA 005 Appeals, on February 2, 2024, and February 22, 2024, by incorporating EQR recommendation of eliminating requirements for filing a written appeal within 10 business days following a verbal appeal. MMM updated the Provider Guidelines and Beneficiary Manual in February 2024 and submitted it to ASES for review and approval. MMM shared the revised P&Ps with the G&A staff and provided verbal updates to the Customer Service Department Manager. CAP will remain unchanged in the	Review and update G&A P&Ps and member and provider materials to align with 42 CFR §438.402 (3)(ii). It is recommended that MMM share revised P&Ps and educate internal departments to include (but not limited to) the Customer Service Department to ensure accurate information is communicated to Enrollees. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), the implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
			CY 2023 findings since CAP activities occurred in 2024.	
The MCO's P&Ps explain the process to inform the Enrollee of their right to and procedures for requesting an Administrative Law Hearing. (GHP 14.6) (42 CFR §438.408(f)) (Act 72 of Sept 7, 1993) (5.3.2.2.3) (5.3.3.3.3) (5.3.4.9) (6.1.1.4) (6.4.5.27.5)	Partially Met	Partially Met	MMM has updated the Provider Guidelines and Beneficiary Manual in February 2024 by including information about how and when an Enrollee can file an ALH and has submitted to ASES for review and approval. As of the virtual on-site review date, approval is pending from ASES. MMM staff noted that the Enrollee resolution letter contains information relating how and when an Enrollee can file an ALH. The English version is missing a sentence which is in the Spanish language version. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Review and update P&Ps and member and provider materials to align with 14.6.1 of the contract. Provide training to MCO staff on updates as needed. It is recommended that MMM reviews the Enrollee resolution letter in the English version to ensure it contains complete information. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), the implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Quality Improvement and Assessment

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330 (b–e).

The intent of this regulation is to ensure the MCO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Findings

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Quality Improvement and Assessment	0	0	0

MMM did not have CAP items in this area from the CY 2022 EQRO review.

PSM

Administration and Organization

Process and Documentation Reviewed

Mercer conducted a desk review of submitted documentation as well as a virtual on-site meeting held June 26, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Senior Compliance Director
- Delegation Oversight Director
- Chief Claims and Information Systems Officer
- Compliance Specialist
- IT Director
- IT Manager
- Project Manager
- Human Resources

Organizational Structure

PSM offers both Medicaid and commercial LOBs in Puerto Rico. The plan serves approximately 163,000 members under the Medicaid LOB and approximately 44,000 under the commercial LOB.

PSM's headquarters are located in San Juan, Puerto Rico. The plan operates 10 service centers across the island located in Aibonito, Cayey, Caguas I, Caguas II, Humacao, Fajardo, Guayama, Ponce, Cidra, and Coamo. The administrative office located in San Juan is open from 8:00 am to 5:00 pm Monday through Friday. The Caguas II office offers extended hours until 7:00 pm on Mondays and the Ponce service center is open the last Saturday of every month from 9:00 am to 5:00 pm (in addition to regular weekly business hours). The Service staff offer Enrollee support related to enrollment processes including issuing ID cards and beneficiary handbooks, forms and responding to inquiries, certificates of coverage, changing an Enrollee's PMG or PCP, managing pre authorizations, explaining benefits, providing orientation to the G&A process, and assisting with claims and payment status.

PSM's organizational and reporting structure has not changed since the last review and there have been no key leadership changes. PSM is led by an executive leadership team comprised of the Finance Department, the CMO, the Executive VP, IT and Claims, the Chief Legal Plan Counselor, and Delegated Entities. The CMO oversees the Clinical Affairs Division which includes UM, Hospital Review, Care Management, and Pharmacy. G&A and

Quality Assurance Management are under the Chief Legal Plan Counselor and the Administrative Officer oversees compliance, delegation, the service and call centers, and enrollment. The Management Services Organization oversees network management and PMG administration. PSM departments range in size from five staff in G&A to 48 in Customer Service. PSM has 262 staff, 200 of which are fully dedicated to Puerto Rico.

Delegated Entities

PSM delegates responsibilities to six different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico	MH — MH benefits, MH provider network credentialing and re-credentialing, MH claims and processing and payment, pharmacy services, MH quality and UM services, BH CM, MH and pharmacy G&A, MH education, reporting, MH Enrollee, and provider call center.
Delta Dental of Puerto Rico	Dental services — Provider network management (PNM) including credentialing and re-credentialing, claims processing and payment, call center, reporting, management of dental services complaints, G&A, and provider disputes.
Jaye, Inc (Telemedik)	Call center services for providers and beneficiaries, nurse advisory line, and reporting.
LinkActiv	Call center services for providers and beneficiaries and reporting.
Provider Network Solutions (PNS) of Puerto Rico	Network services — Network management and reporting.

PSM has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities and has a dedicated unit, the Delegation Oversight team, which is responsible for all subcontractor oversight activities. PSM utilizes a two-tier monitoring process. The first tier monitors day-to-day activities of operational areas. Second tier monitoring focuses on regulatory, contractual requirements, and performance guarantees. PSM's policies indicate that PSM allows for sub-delegation under delegated entities.

Accreditation

PSM's delegate APS Health of Puerto Rico, Inc. (APS) has an active Utilization Review Accreditation Commission (URAC) accreditation and completed the re-accreditation process in August 2020 and September 2022. APS has delegated responsibility for BH services for

PSM. Provider Network Solutions of Puerto Rico, Inc. (PNS), another PSM delegate which is responsible for provider network management, is NCQA accredited for 2024.

Employee Training

All PSM employees receive training on cultural competency, FWA, and HIPAA. Customer Service center, provider network and member services staff are trained on advance directives, Enrollee rights and provided with a Medicaid overview. The clinical team also receives a training specific to BH. PSM subcontractors and delegates are required to complete some or all of these training topics (as appropriate to their role). All trainings are provided to new hires, annually or as needed depending on roles and most are delivered virtually.

Enrollee Rights and Protections

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MCO complies with the state enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MCO has written policies related to Enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable state and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MCO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MCO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (i).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under state law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the state laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 26, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Senior Compliance Officer
- Health Education and Wellness Director
- Call Center Supervisor
- Executive VP
- Services Manager
- Compliance Specialist

Overall Assessment

For Enrollee Services, PSM had three open CAP items from CY 2022. The first CAP item pertains to advance directives, including the Enrollee rights associated with advance directives, reading level requirements, and the age at which Enrollees should receive information about advance directives. PSM has updated the P&P pertaining to advance directives (PSM SRV-017 Advance Directives, effective 2/25/2024) to reflect all CFR and contractual requirements. Policy changes have been incorporated into the beneficiary manual, the webpage, and educational materials. Customer Service and Care Management staff were trained on the policy changes in March 2024.

The second open CAP item pertains to Enrollee rights to receive their medical records in accordance with CFR and contractual requirements. In the prior review, PSM had addressed this requirement in their employee training and within the beneficiary manual. PSM has now incorporated these requirements into the Enrollee Services P&P (PSM SRV-005), with an effective date of March 19, 2024. The requirements are broadly stated; however, during the virtual on-site review, PSM provided examples of the welcome and educational call scripts used by customer service representatives. These scripts included a review of Enrollee rights, including how to request and obtain their own medical records. This demonstrated how the requirements are operationalized at the member-facing level.

The third open CAP item pertains to moral and religious objections issued by providers which result in a refusal to cover, reimburse, refer, or prior authorization any service with the scope of the detailed covered services. During the virtual on-site review, PSM shared that the provider guidelines have been amended but they are pending approval from ASES. The amended guidelines were sent to ASES on March 8, 2024, and there has been back and forth feedback from ASES into June 2024. The changes in policy have been incorporated into new employee onboarding training and annual employee training. They have also been incorporated into the scripts used by Customer Service staff when conducting welcome and educational calls.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Enrollee Rights and Protections	3	0	3

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that comply with: written at a fourth grade reading level in English and Spanish; provided to Enrollees 18 years of age and older; (7.10.1) advise Enrollees of their rights under the laws of Puerto Rico to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; the implementation of those rights, including a statement of any limitation regarding implementation of Advance Directives as a matter of conscience; and the Enrollee's right to file complaint or grievance concerning noncompliance with Advance Directive requirements directly with ASES or with the Puerto Rico Office of the Patient Advocate. (14.9) The P&Ps reflect a description of Puerto Rico law and requires the MCO to reflect changes in laws as soon as possible and no later than 90 calendar days after the effective change (7.10). (42 CFR § 438.3(j)), 42 CFR	Partially Met	Partially Met	PSM has updated the P&P pertaining to advance directives (PSM SRV-017 Advance Directives, effective 2/25/2024) to reflect all CFR and contractual requirements. Policy changes have been incorporated into the beneficiary manual, the webpage, and educational materials. Customer Service and Care Management staff were trained on the policy changes in March 2024. The CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Continue all planned CAP activities in 2024, including, but not limited to, evidence of future training and training dates related to the implementation of the policy, oversight, and monitoring of implementation. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy and provider directory will require completion during CY 2024.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
422.128(a), 42 CFR.128(b), 42 CFR 489.102(a), and Law No. 160 of Nov 17, 2001.				
The MCO P&Ps for the Enrollee rights to receive information are pursuant to 42 CFR 438.10 and complies with Section 6.5.	Partially Met	Partially Met	PSM has updated the Enrollee Services Policy (PSM SRV-005), with an effective date of March 19, 2024. The requirements pertaining to Enrollee rights to receive information are broadly stated. However, PSM provided examples of the welcome and educational call scripts used by Customer Service representatives. These scripts included a review of Enrollee rights, including how to request and obtain their own medical records. This demonstrated how the requirements are operationalized at the member-facing level. The CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Continue all planned CAP activities in 2024, including, but not limited to, evidence of future training and training dates related to the implementation of the policy, oversight, and monitoring of implementation. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy and provider directory will require completion during CY 2024.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that describe the use of any moral or religious objections to cover, reimburse, refer, or prior authorize any service with the scope of the detailed covered services. The P&Ps include notification to ASES, Enrollees, and potential Enrollees as provided in 7.13.1 of the contract. (42 CFR § 438.102(b) and 42 CFR § 438.10(g)(2)(ii)(A and B)) The MCO has P&Ps that permit the Enrollee to change PCP due to moral or religious conflict. (5.4.1.5.1)	Not Met	Not Met	PSM's provider guidelines have been amended but they are pending approval from ASES. The amended guidelines were sent to ASES on March 8, 2024, and there has been back and forth feedback from ASES into June 2024. The changes in policy have been incorporated into new employee onboarding training and annual employee training. They have also been incorporated into the scripts used by Customer Service staff when conducting welcome and educational calls. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Continue all planned and active CAP activities in 2024 to reach compliance for this CAP item including, but not limited to, finalization of the provider guidelines, evidence of notification to providers of the policy change, and future training and training dates related to the implementation of the policy, oversight, and monitoring of implementation. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy and provider directory will require completion during CY 2024.

Provider Network

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214 (c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MCO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with state requirements. The MCO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MCO has P&Ps in place which guarantee the MCO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MCO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MCO obtains State approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To meet the requirements for the CAP review, PSM submitted documentation such as trainings, new P&Ps, and the annual network development and management plan as well as targeted responses to the outstanding finding from the CY 2023 comprehensive review. This review was conducted based on information submitted by the MCO through the RFI and through a virtual on-site meeting held June 26, 2024. This meeting involved participation from MCO key leadership including, but not limited to:

- Analytics Unit Supervisor, PNS
- Configuration Lead
- Senior Compliance Director
- Health Education and Wellness Director
- VP of Regulatory Affairs, APS
- Human Resource Technician
- Compliance Officer, PNS
- Executive VP
- Chief Financial Officer, PNS
- Integrity Officer
- Compliance Specialist
- Director, PNS
- Provider Network Director

Overall Assessment

There were five topic areas where follow up information was requested to meet the standards. Within the desk review submission, PSM responded to each item, resulting in two items identified as met and the remaining three as partially met, as PSM has a plan in place, however the final documents providing evidence of the planned changes outstanding.

The following two CAP items have been met:

- From the comprehensive review, APS' P&Ps did not include the process for ensuring access to BH-covered services, PSM provided the following APS policies: Accessibility of BH and Availability of BH Providers both with a revision date of March 15, 2023, showing availability of BH covered services as well as the APS Provider Manual which was updated April 2023.
- For oversight of delegation entities for network management activities during the comprehensive review, the PSM submission did not include agreements for Agilerta. For the desk review submission, PSM provided a description of Agilerta's responsibilities

(Agilerta provide PSM credentialing services to PSM's GHP's populations. The credentialing services include the following activities: complete the Credentialing Application and credentialing file; Screen all credentialed providers against the federal databases specified in 42 CFR 455.436 on a monthly basis to ensure providers are not excluded; perform Physician's Puerto Rico License Sanction Validation. When the credentialing file is completed, Agilerta sends the case to PSM. PSM Credentialing Committee reviews the credentialing file and determines if the provider is approved or denied. PSM clarified that Agilerta was in place as a delegated entity from 2018–2022. The company is no longer in business and was no longer a delegated entity as of 2023. PSM provided written explanation of this change.

The following three CAP items require further action and have been scored as Partially Met:

- The PSM Provider Directory includes the following available fields: name, specialty, group affiliation, locations, office hours, phone numbers, websites, cultural and linguistic capabilities, accommodation for people with disabilities and identification of providers in the network who are accepting new patients. The directory does not include if the provider completed cultural competency training as contractually required. PSM submitted a plan for updating the provider directory with a notation of cultural competency training completion with a targeted completion date of July 31,2024.

- Neither the provider contracts, nor other documentation provided evidence of requiring PCP adherence to administering the Modified Checklist for Autism in Toddlers ("M-CHAT R/F") screening tool, following the "Protocolo Uniforme de TEA" government plan version, published by the Department of Health and administered to the parents of child, Enrollees the Ages and Stages Questionnaire ("ASQ"), or in the alternative, the Survey of Well-being of Young Children (SWYC") to the parents of child.

  Enrollees as required in the Plan Vital Contract. PSM amended the policy regarding PCP contracts to include requirement of Autism screening, however the new contract language must be approved by ASES, and notification sent to PCP providers informing them of this updated contract agreement. PSM will submit the updates to ASES and put into place with providers.

- PSM submitted the Standard Operational Procedure (SOP) CO-S-007 for Provider Termination Process – Vital and Commercial (Non-PCP),' which covers various aspects of provider termination. The document provides an overview of how to handle client termination requests, terminations identified by Provider Network Solutions (PNS), the cancellation process initiated by providers, examples of termination instances in client service contracts, and the provider termination logbook. However, the SOP lacks a specified process for informing ASES of provider terminations, a requirement under Contract Requirement 18.2.5.4. PSM amended the language within the Provider Termination Process – Vital and Commercial (Non-PCP) for provider termination reporting and included the process to track providers that are no longer contracted.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Provider Network	5	2	3

The table below lists delegated entities for network management activities.

Delegated Entity	Type of Entity and Services
Providers Network Solutions of Puerto Rico, LLC	Physical Provider Network Management, credentialing and re-credentialing, and reporting
APS Health Puerto Rico, Inc.	Behavioral Providers Network management including credentialing and re-credentialing, reporting, claims processing, and payment
Delta Dental of Puerto Rico, Inc.	Dental Providers Network management including credentialing and re-credentialing, reporting, claims processing and payment

The table below outlines an overview of the MCO network.

Provider Type	Number of Providers in CY 2023
Primary Care Physician (PCP) (total)	1,419
Adult	1,129
Pediatric	1,348
Primary Medical Groups (PMGs)	81
Obstetrics and Gynecology (OB/GYN) Providers	261
Hospital	49
FQHC	17
Urgent Care	6
Nursing Facility	1
Adult and Pediatric Dental Providers	629
Vision	297

Provider Type	Number of Providers in CY 2023
Adult High Volume Specialty Care Providers (total)	603
Cardiology	213
Endocrinology	54
Oncology	123
Nephrology	105
Pulmonology	110
Pediatric High Volume Specialty Care Providers (total)	613
Cardiology	213
Endocrinology	55
Oncology	116
Pulmonology	108
Speech, Language, and Hearing	123
Psychiatric Hospitals	13
Psychiatric Partial Hospitals	34
Adult and Pediatric Mental Health Providers (Psychologist, Psychiatrist, Licensed Clinical Social Worker and/or Licensed Professional Counselor)	1,016
SUD Inpatient Detoxification and/or rehabilitation	17
SUD Intensive Outpatient (IOP) and/or partial hospitalization provider (PHP)	40
Addiction Medicine/Withdrawal Management Provider	41

Findings

Regulation/Co Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has a Provider Directory in place and P&Ps describing how the provider directory is accessible, updated, frequency of updates and validation of information in its provider directory, including the data elements listed in Section 6.6. (42 CFR § 438.10(h)) (6.10.1, 6.10.8 Amendment A, 6.10.9)	Partially Met	Partially Met	The Provider Directory does not include if the provider completed cultural competency training as contractually required. PSM submitted a plan for updating the provider directory with a notation of cultural competency training completion. PSM has developed an electronic mailer regarding the cultural competency plan training and will then collect the information from providers to be able to include a notation in the directory with a targeted completion date of July 31,2024. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy and Provider Directory will require completion during CY 2024.

Regulation/Co Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO's provider recruitment P&Ps include effective strategies to ensure adequate access to all covered services in accordance with Puerto Rico's access standards that include appointment availability timeframes for non-urgent/urgent conditions, access to services for Enrollees with special healthcare conditions, monitors providers hours of services including BH and PMG providers. (9.5.1-5) Medicaid: (42 CFR § 438.206(c)(1)) & CHIP: (42 CFR § 457.1230(a)) (Attachment 2 and 20) (42 CFR 438.68) (18.3.1.7)	Partially Met	Met	All requirements for these metrics have been met through RFI documents, virtual on-site discussions, and/or post on-site submissions.	None
The MCO has P&Ps to ensure provider contracts comply with 10.3 and Amendments A and M of the contract. Including contract compliance with Autism context in 7.7.9. (7.1.18) (7.7.9.2) (9.2.3.7) (10.1.6) (10.3)	Partially Met	Partially Met	PSM stated that evidence of the PCP/PMG adherence to administering the MCHAT will be added to the Physician Contract Agreement and will be sent to ASES for review and approval after it's added prior to execution of the updated contracts. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the PCP/PMG contracts will require completion during CY 2024 for submission.

Regulation/Co Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCOs have written P&P for provider termination that comply with 10.4 and reporting of provider terminations and suspensions. (18.2.5.4)	Partially Met	Partially Met	The standard operation procedure workflow has been updated to include the process of information ASES of provider terminations as contractually required. This update took place in 2024. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy for provider terminations will require completion during CY 2024 for submission.
The MCOs have P&Ps in place for subcontractor relationships (Article 30) Medicaid. (42 CFR § 438.230), CHIP: (42 CFR § 457.1233(b))	Partially Met	Met	All requirements for these metrics have been met through RFI documents, virtual on-site discussions, and/or post on-site submissions.	None

Care Management

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MCO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held on June 26, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- CMO
- Medical Director
- Senior Compliance Director
- UM Manager
- Privacy Officer
- Executive Assistant
- Care Management Manager
- VP of Clinical Affairs, APS
- Director of UM, APS

Overall Assessment

The CY 2022 EQR identified three findings that required a CAP within the Care Management requirements for PSM.

42 CFR § 438.208, 42 CFR § 438.62, and the MCO contract article 6.1.8 require PSM to ensure continued access to services during an Enrollee's transition from one Contractor to another. During the CY 2022 review, Mercer was unable to find language describing how Enrollees can access continued services and recommended PSM to revise the Beneficiary Manual to include language educating Enrollees on how they can access continued services pursuant to the transition of care process. In response to the CAP, PSM drafted revised language for the Beneficiary Manual in 2024 and shared it with Mercer during the virtual on-site review. As of the virtual on-site review date, the proposed changes to the Beneficiary Manual are pending approval from ASES.

The second CAP item pertains to actively linking the Enrollee to providers and health care services through telehealth, telemedicine, and teledentistry per the MCO contract articles 7.8.2.3.7 and 7.1.6. During the CY 2022 review, PSM provided policy illustrating promotion of access to Care Manager, PCP, and specialized provider visits using alternate visits (telephone/telehealth/telemedicine) and detailed its expansion of telehealth capacity with tablets, educating providers and Enrollees about telehealth. However, PSM's P&Ps did not address the availability and use of teledentistry, and was recommended to develop a P&P. In response to the CAP, PSM submitted P&Ps developed in February 2024 by Delta Dental Puerto Rico, a dental vendor. The teledentistry policy contains information on the availability of teledentistry to enhance access for the Enrollees. The policy also contains information on the use of teledentistry codes, technology vehicles, and mode of communication. During the virtual on-site review, PSM staff indicated that it implemented teledentistry services in direct response to a Regulatory Letter issued by ASES in 2020. As of the virtual on-site review date, PSM has not submitted P&Ps to ASES for review and approval and has not provided education to providers and Enrollees about the availability of teledentistry.

The third CAP item pertains to developing treatment plans by the Enrollee's PCP, with the Enrollee participation, and in consultation with any specialists caring for the Enrollees when they qualify for both Special Coverage and the High-Cost High Need (HCHN) Program per the MCO Contract. During the CY 2022 review, PSM provided P&Ps and demonstrated its compliance with P&Ps to complete, monitor, and routinely update treatment plans for each Enrollee who is registered for Special Coverage. However, there was no language in the P&Ps providing guidance on support of Enrollees that are eligible for both Special Coverage and HCHN and the treatment planning requirements when Enrollees qualify for both programs. As of CY 2023, the HCHN Program is no longer required per the ASES contract. Therefore, the CAP for this item has been closed.

Of the three CAP items identified, PSM closed out one CAP and has two CAP items remain open as outstanding items.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Care Management	3	1	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that provide: Details and support of an ongoing source of care for Enrollees appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The process for the MCO to provide information to the Enrollee on how to contact their designated person or entity. Coordination efforts P&Ps shall include consultation with Enrollee's PCP. Instructions to Enrollees and Potential Enrollees in the Enrollee Handbook and notices approved by ASES on how to access continued services pursuant to its transition of care process (42 CFR § 438.208) (7.8.2.5) (7.8.2.4.6) (42 CFR § 438.62) (6.1.8 Amendment A).	Partially Met	Partially Met	During the virtual on-site review, PSM shared proposed edits to the Beneficiary Manual, which contains additional clarifying language about how an Enrollee can access services while transitioning from another health plan. PSM sent a request to ASES in early June 2024 with suggested edits to the Beneficiary Manual. As of the virtual on-site review date, the Beneficiary Manual is pending approval by ASES. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Revise the Beneficiary Manual to include language educating members on how they can access continued services pursuant to the transition of care process. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), provide revised P&Ps, all training and education provided to staff, providers, and Enrollees related to the implementation of P&Ps, oversight, and monitoring of implementation.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps on: Coordination of Care that actively links the Enrollee to providers, medical services, residential, social, and other support services, including coordination of care between MCOs, settings of care and discharge planning for short and long-term hospital and institutional stays, and from community and social support providers. The availability of healthcare services through telehealth, telemedicine, and teledentistry. (42 CFR § 438.208(b)(2)) (7.8.2.3.7) (7.1.6 Amendment M)	Partially Met	Partially Met	PSM's delegate, Delta Dental Puerto Rico developed P&Ps on teledentistry, in February 2024. As of the virtual on-site review date, PSM has not submitted P&Ps to ASES for review and approval, and there was no evidence of providing information to providers and Enrollees about the availability of teledentistry. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Develop a P&P that addresses the availability of healthcare services through teledentistry. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), provide revised P&Ps, all training and education provided to staff, providers, and Enrollees related to the implementation of P&Ps, oversight, and monitoring of implementation.
The MCO has P&Ps that include: Treatment plans be developed by the Enrollee's PCP, with the Enrollee's participation, and in consultation with, any specialists caring for the Enrollee. Treatment plans and are reviewed and revised at least every 12 months, when needs change significantly, or at the request of the Enrollee; and include treatment plan elements as described in 7.8.2.4 of the MCO contract.	Partially Met	Met	All requirements for these metrics have been met through RFI documents, virtual on-site discussions, and/or post on-site submissions.	None

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
Processes in the event an Enrollee qualifies for both Special Coverage and the HCHN Program, where the treatment plan developed under the HCHN program must comply with the Special Coverage provisions. (42 CFR § 438.208(c)) (7.7.8) (7.7.8.1)				

Utilization Management (UM)

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 26, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- CMO
- VP of Clinical Affairs
- Senior Compliance Officer
- Privacy Officer
- UM and Pharmacy Director, PSM
- UM Supervisor
- Pharmacy Manager, APS
- Care Management Manager

Overall Assessment

To address the requirements for the UM CAP review, PSM submitted documentation such as the RFI narrative and the APS UM program description as responses to the outstanding findings from the CY 2022 review.

There was one topic area where follow-up information was requested to meet the standards. Within the desk review submission, PSM provided a response indicating that there is a policy for PSM and APS that adheres to the contractual and federal requirement for parity, and that a parity analysis was conducted in March 2024. However, neither of these documents were submitted with the initial submission or following the virtual on-site review. The CAP score will remain as Partially Met.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Utilization Management (UM)	1	0	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has written P&Ps that: (i) identify, define, and specify the amount, duration, and scope of each covered service and benefit	Partially Met	Partially Met	PSM reports parity is addressed by covering BH services and ensuring the processes to obtain services are not	Develop P&Ps to demonstrate adherence to 42 CFR part 438, subpart K and 42 CFR § 438.910(d) regarding parity in BH services.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
(including any quantitative and non-quantitative. The MCO has P&Ps to ensure all Enrollees are provided access to a set of services that meets the requirements of 42 CFR part 438, subpart K and 42 CFR§ 438.910(d) regarding parity in BH services, regardless of what BH services are provided by the contractor. (GHP 7.5.11.6.7 Amendment A)			stricter than on the Physical Health side. PSM reports that they have a policy for parity. PSM submitted a policy on Interrater reliability which is not the same as parity. A parity analysis was completed but this document was not submitted for review. The APS BH UM program states that APS holds meetings with MCG leaders to discuss items related to the UM process including compliance with MHPAEA. While this is good practice and potentially provides supporting information, as the contract holder PSM is required to develop, implement and monitor a P&P for parity. CAP will remain unchanged in the 2023 findings.	Submit a parity analysis or a timeframe for completing a parity analysis. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), provide revised P&Ps, all training and education provided to staff, oversight, and monitoring of implementation.

Grievance and Appeals (G&A)

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MCO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all G&As filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 26, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Senior Compliance Director
- Chief Plan Legal Counsel
- Privacy Officer
- G&A Specialist
- Senior Compliance Director, APS
- Quality Manager, APS
- G&A Supervisor, APS

Overall Assessment

The CY 2022 EQR identified two findings that required a CAP within the G&A requirements for PSM. The first item pertains to the Enrollee's ability to file an appeal either orally or in writing per the MCO contract articles 14.5.2, 14.5.4. During the CY 2022 review, Mercer noted that while PSM updated G&A P&Ps to reflect that a verbal request for an appeal does not need to be followed by a written appeal, however, member and provider materials to did not reflect the updated PSM P&Ps. As a result, Mercer recommended PSM to review and revise member and provider materials and provide training to PSM staff to ensure the policy change is operationalized as necessary.

In response to the CAP, PSM updated P&Ps, G&A 001 Complaints, Grievances, and Appeals, on November 13, 2023, by deleting the reference that a verbal request for an appeal must be followed by a written appeal. Following P&Ps revision, PSM provided internal training to the Customer Service Department. Regarding requirements for reviewing and revising member and provider material, PSM submitted a request to ASES on June 12, 2024, with suggested edits to the Beneficiary Manual and has updated the website to reflect correct requirements. PSM also revised the Provider Manual and communicated with APS, who provides BH services, to comply with the revised policies on December 11, 2023. Subsequently, APS has revised P&Ps, GA 01, Complaints, Grievances and Appeals Process for the Government Health Plan, on December 21, 2023, and updated the 2023 Participating Provider's Manual, A Guide for Contracted Providers and Facilities.

The second CAP item pertains to informing ASES of appeal decisions within two business days of the resolution according to 14.5.14 of the MCO contract. During the CY 2022 review, Mercer noted that PSM informed ASES quarterly of the number of appeals received, processed, how many were overturned or upheld (in full or in part), reasons for the appeal for physical health and BH services, and number of appeals resolved and recommended that

PSM review and revise P&Ps to reflect informing ASES of appeal decisions within two business days of the resolution.

In response to the CAP, PSM revised P&Ps, G&A 001 Complaints, Grievances, and Appeals, on November 13, 2023, to include informing ASES of appeal decision within two business days of the resolution in accordance with the MCO contract section 14.5.14 and has informed staff of the policy revision. Additionally, PSM required APS to update their policy to comply with PSM's updated policy, and APS has revised P&Ps, GA 01, Complaints, Grievances and Appeals Process for the Government Health Plan, on December 21, 2023. However, PSM has not operationalize the policy as of the review date as it has not requested access to the ASES' FTP server.

Out of two CAP items identified, two CAPs remain open as outstanding items.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Grievance and Appeals (G&A)	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 calendar days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal within 10 calendar days. (42 CFR §438.402 (2)(ii)) (GHP 14.3.3, 14.5.2, 14.5.4)	Partially Met	Partially Met	PSM updated P&Ps on November 13, 2023, by deleting the reference that a verbal request for an appeal must be followed by a written appeal. PSM provided internal training to the Customer Service Department. PSM submitted a request to ASES on June 12, 2024, with suggested edits to the Beneficiary Manual and has updated the website to reflect correct requirements. PSM also revised the Provider Manual and communicated with APS, who provides	Review and revise member and provider materials to reflect the updated MCO policy. Provide training to MCO staff to ensure the policy change is operationalized as necessary. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), provide revised P&Ps, all training and education provided to staff, providers, and Enrollees related to the implementation of P&Ps, oversight, and

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
			BH services, to comply with the revised policies on December 11, 2023. APS revised P&Ps on December 21, 2023, and updated the 2023 Participating Provider's Manual, A Guide for Contracted Providers and Facilities. CAP will remain unchanged in the CY 2023 findings since CAP activities occurred in 2024.	monitoring of implementation.
The MCO's P&Ps clearly state time frames for standard resolution of appeals and notification of the decision within 30 calendar days. (42 CFR §438.408) Written Notice of Disposition of an appeal is provided to the Enrollee ASES within two business days of the decision. (14.5.14, 14.5.15 and 14.5.9) (Section 14.5 GHP)	Partially Met	Partially Met	PSM revised P&Ps on November 13, 2023, to include requirements of informing ASES of appeal decision within two business days of the resolution and has informed staff of the policy revision. PSM required APS to update their policy to comply with the PSM's updated policy, and APS has revised P&Ps on December 21, 2023. However, PSM has not operationalized the policy. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Review P&Ps and expectations for informing ASES of appeal decisions within two business days of the resolution according to 14.5.14 of the contract. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), provide revised P&Ps, all training and education provided to staff, providers, and Enrollees related to the implementation of P&Ps, oversight, and monitoring of implementation.

Quality Improvement and Assessment

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330 (b–e).

The intent of this regulation is to ensure the MCO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of PSM's CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 26, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Chief Plan Legal Counsel
- Senior Compliance Director
- Director of Quality
- Quality Assurance Specialist
- Privacy Officer
- VP of Clinical Affairs, APS
- Quality Manager, APS

Overall Assessment

The CY 2022 EQR identified one finding that required a CAP within the Quality Improvement and Assessment requirement for PSM. 42 CFR § 438.330(d)(1) and MCO contract article 18.2.6.2 require PSM to develop P&Ps that support timely, complete, and accurate submission of a quarterly Quality Improvement Performance (QIP) report. Findings from the CY 2022 review stated that while PSM staff members articulated a thorough process for collecting, analyzing, and reporting data to support timely, complete, and accurate submission of quarterly (QIP) reports, it did not have written P&Ps describing the process.

In response to the CAP, PSM developed a Standard Operating Procedure (SOP) on February 27, 2024, that describes the method it has in place to support timely, complete, and accurate submission of the QIP reports. The SOP also identifies all the data sources and delineates the roles and responsibilities of the Quality and IT staff as well as vendors i.e., APS for BH, Delta Dental for oral health, a certified NCQA vendor that generates monthly and annual HEDIS reports and the timelines and processes for completing data validation.

CAP item remains open as outstanding in the CY 2023 findings since the CAP activity occurred in CY 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Quality Improvement and Assessment	1	0	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO's PIP work plan and P&Ps support timely, complete, and accurate submission of a quarterly QIP Report. (42 CFR § 438.330(d)(1)) (18.2.6.2) (Article 18)	Partially Met	Partially Met	PSM created an SOP, for its Data Validation Process for Quality Reporting, on February 27, 2024. The SOP describes the method to support timely, complete, and accurate submission of the QIP reports. The SOP also identifies all the data sources and delineates the roles and responsibilities of the Quality and IT staff as well as its vendors. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Develop P&Ps that outlines how PSM ensures timely, complete, and accurate submission of quarterly QIP Reports. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025), provide revised P&Ps, all training and education provided to staff, providers, and Enrollees related to the implementation of P&Ps, oversight, and monitoring of implementation.

Triple-S

Administration and Organization

Process and Documentation Reviewed

Mercer conducted a desk review of submitted documentation as well as a virtual on-site meeting held June 27, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- VP of Performance Compensation and Benefits
- Compliance Service Unit Manager
- Financial Planning and Analysis Director
- Privacy Officer
- Compliance Audit and Monitoring Director
- Compliance Auditor
- Customer Service Senior Manager

Organizational Structure

Triple-S Salud (TSS) is a subsidiary of Triple-S Management (TSM) Corporation which also includes Triple-S Advantage (TSA) (Medicare Advantage), Triple-S Vida (life insurance) and Triple-S Propiedad (property and casualty insurance). In 2022, Guidewell Mutual Holding Corporation (GMHC) acquired TSM making it a wholly owned subsidiary of GMHC. TSM offers commercial, federal, Medicaid, and Medicare Advantage LOBs in Puerto Rico. The Medicaid line of business is the largest with 468,843 members, followed by Commercial at 439,652. Medicare and federal business have much lower enrollment with 78,009 and 51,720 respectively. TSS and TSA are Blue Cross Blue Shield (BCBS) licensees and have the exclusive right to use the BCBS name and logo.

The Triple-S headquarters are located in San Juan, Puerto Rico. The plan offers 16 service centers across the island which can directly assist members with various requests including printing ID cards and filing grievances. The general hours are 8 am to 5 pm, Monday through Friday, or 9 am to 6 pm, Sunday through Friday. Two service centers are open on Mondays from 8 am to 7 pm; and, one Saturday per month from 8 am to 5 pm.

The GHP organizational structure falls under an Executive Affairs Administrator who reports directly to the CEO. This administrator oversees the General Manager of Medicaid, the COO, CMO, and the Strategic Initiatives Manager. Triple-S employs approximately 2,350 staff and report that nine positions are solely dedicated to Plan Vital;1,675 positions are shared across LOB and 832 are dedicated to Medicare. Key departments include Enrollee Services, G&A, UM, Quality, Network/Provider Services, Coordination of Care and Pharmacy.

The COO oversees UM (including preauthorization and facility-based care management), health management, contracting and administration, service administration (including call centers), innovation and integration, and provider relationships and partnerships. The Chief Strategy Officer manages contracting and administration, clinic networks, provider relationships and partnerships, healthcare service and quality integration, and population health management. The CMO oversees the medical management advisor, plus the Departments of Medical Quality, Integrated Delivery System, Pharmacy, G&A, HEDIS and Stars, and the QI Medical Director.

Triple-S reports some changes in structure/positions since the last review. In November 2023, the following changes were implemented:

- A new role, VP of Operational Performance, was created.
- The UM/Care Management and Health Management teams were combined under a single operation and will report to the Senior VP of Clinical Operations. A new hire began in this position on November 13, 2023.
- A new CFO was hired in September 2023 and the Network Strategic Function will fall under this position.

The Triple-S Executive Team oversees all LOBs.

Delegated Entities

Triple-S delegates responsibilities to five different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico	Mental Health (MH) — MH benefits, MH provider network credentialing and re-credentialing, MH claims and processing and payment, pharmacy services, MH quality and UM services, BH care management, MH and pharmacy G&A, MH education, reporting, MH Enrollee, and provider call center.
Oncology Analytics (dba OncoHealth)	Oncology-related UM approvals.
Optum	Claims processing, IT.
Pager and Beeper Medical Group	Nursing advice line.
Telemedik	PSG call center for Medicaid Enrollees.

Triple-S has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities. Oversight of delegated entities fall under the Triple-S compliance and privacy officer, but other departments have a role in oversight as well:

- Contract Administrators are responsible for tracking and monitoring the delegated entity performance and day to day oversight for compliance issues.

- Subject Matter Experts evaluate reports produced and submitted by delegated entity, and review P&Ps related to their areas of expertise.
- The Compliance Department conducts audits and monitoring to test and confirm compliance and conducts compliance to compliance meetings on an at least quarterly basis.
- The Special Investigation Unit conducts the activities related to the prevention, detection, and referrals of potential FWA activities.
- The Vendor Management Oversight Committee reviews delegated entity performance as reported by Contract Administrators.

Accreditation

Triple-S did not report any accreditations during this report period. It is important to note that holding accreditations is not an existing contractual requirement.

Employee Training

Triple-S requires all newly hired employees to complete a training curriculum through a Learning Management System which includes topics such as a review of the Triple-S compliance program, advance directives, cultural competency, FWA, Elderly Financial Exploitation, Code of Business Conduct and Ethics, HIPAA, and a Medicaid overview. Customer Services and G&A staff are required to also complete a training on G&A. Delegated entities must take trainings covering FWA, HIPAA, Code of Business Conduct and Ethics and a Medicaid overview, and UM-delegated entities participate in IRR. All staff must complete these trainings annually thereafter. Triple-S utilizes a variety of formats to train employees, including online trainings, in-person class trainings and written educational materials.

Enrollee Rights and Protections

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MCO complies with the state enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MCO has written policies related to Enrollee rights and ensure the MCO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable state and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MCO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MCO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MCO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives, including their rights under state law, and must contain clear and concise language on the limitation if the MCO cannot implement an advance directive as a matter of conscience. The MCO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the state laws. The MCO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MCO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MCO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MCO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple-S CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 27, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Manual Enrollment Manager
- Customer Service Director
- Compliance Regulatory Lead
- Enrollment Director
- Enrollment Representative
- Compliance Auditor

Overall Assessment

Triple-S had one open CAP item from CY 2022 pertaining to processes for providers to follow when a provider issues a moral and religious objection resulting in a refusal to provide, reimburse or not provide a referral or prior authorization based on an objection of this type. Triple-S provided evidence of an updated P&P (TSS-NM-05 – Written Agreements for Participating Providers – effective date 4/5/2024). The policy indicates the process for providers to follow when they issue a moral or religious objection and the notification timelines for Enrollees, ASES, and the MCO. Triple-S is in process of updating the provider guidelines to reflect these policy changes and will submit the final version to ASES for review in July 2024. Once approval is obtained, Triple-S will notify providers of this policy change. Internal staff were notified of the policy change on May 24, 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Enrollee Rights and Protections	1	0	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that describe the use of any moral or religious objections to cover, reimburse, refer, or prior authorization any service with the scope of the detailed covered services. The P&Ps include notification to ASES, Enrollees and potential Enrollees as provided in 7.13.1 of the contract. (42 CFR § 438.102(b) and 42 CFR § 438.10(g)(2)(ii) (A and B)) The MCO has P&Ps that permit the Enrollee to change PCP due to moral or religious conflict. (5.4.1.5.1)	Not Met	Not Met	Triple-S provided evidence of an updated P&P, TSS-NM-05 – Written Agreements for Participating Providers (effective date 4/5/2024). The policy indicates the process for providers to follow when they issue a moral or religious objection and the notification timelines for Enrollees, ASES, and the MCO. Triple-S is in process of updating the provider guidelines to reflect these policy changes and will submit the final version to ASES for review in July 2024. Once approval is obtained, Triple-S will notify providers of this policy change. Internal staff were notified of the policy change on May 24, 2024. CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024. Other components of this requirements were scored as “Met” in the prior review and were not included in this review.	Continue all planned and active CAP activities in 2024 to reach compliance for this CAP item, including, but not limited to, evidence providers have been notified of the policy change and that staff have been trained on all changes. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy (including the analysis) will require completion during CY 2024 submission.

Provider Network

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MCO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MCO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MCO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MCO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214 (c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214 (d) prohibits the MCO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with state requirements. The MCO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MCO has P&Ps in place which guarantee the MCO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MCO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MCO obtains state approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To meet the requirements for the CAP review, Triple-S submitted documentation such as trainings, new P&Ps, and the annual network development and management plan as well as targeted responses to the outstanding finding from the 2023 comprehensive review. This review was conducted based on information submitted by the MCO through the RFI and through a virtual on-site meeting held June 27, 2024. This meeting involved participation from MCO key leadership including, but not limited to:

- Compliance Regulatory Lead
- Regulatory and Vendor Management Administrator
- Network Administration Senior Manager
- Compliance Auditor

Overall Assessment

Triple-S reports a stable network and has not seen additional barriers or obstacles for the review in CY 2023.

As part of the CAP review process, Mercer requested follow up documentation regarding the P&Ps for second opinion coverage, and for the cultural competency plan. Triple-S provided documentation verifying changes were made to the existing P&Ps to ensure second opinion coverage at no cost to the member regardless of if the provider is in or out of network.

The second recommendation from Mercer was for Triple-S to provide verification that the cultural competency plan goes through the ASES approval process and that there is a documented process to distribute the cultural competency plan to providers. Triple-S provided updates to the GHP Cultural Competency policy to include the process for providers to access the cultural competency plan in various ways including the Triple-S provider website, the provider manual and through bulletins and circular letters.

As the updates for both CAP items were completed in 2024, the CAP items will remain unchanged.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Provider Network	2	0	2

The following subcontractor supports Provider Network functions:

Delegated Entity	Delegated Services
APS Healthcare Puerto Rico	BH network management activities, including contracting and credentialing.

The table below outlines an overview of the MCO network.

Provider Type	Number of Providers in CY 2023
Primary Care Physician (PCP) (total)	2,649
Adult	1,207
Pediatric	1,442
Primary Medical Groups (PMG)	81
Obstetrics and Gynecology (OB/GYN) Providers	457
Hospital	57
FQHC	52
Urgent Care	92
Nursing Facility	3
Adult and Pediatric Dental Providers	1,070
Vision	142 (optical)
Adult High Volume Specialty Care Providers (total)	1,072
Cardiology	388
Endocrinology	134
Oncology	101
Nephrology	246
Pulmonology	203
Pediatric High Volume Specialty Care Providers (total)	1,041
Cardiology	388
Endocrinology	134
Oncology	101
Pulmonology	203
Speech, Language and Hearing	215
Psychiatric Hospitals	11
Psychiatric Partial Hospitals	33

Provider Type	Number of Providers in CY 2023
Adult and Pediatric Mental Health Providers (Psychologist, Psychiatrist, Licensed Clinical Social Worker and/or Licensed Professional Counselor)	1,499
SUD Inpatient Detoxification and/or rehabilitation	11
SUD Intensive Outpatient (IOP) and/or partial hospitalization provider (PHP)	11
Addiction Medicine/Withdrawal Management Provider	17

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has established P&Ps on provider recruitment, retention and termination and describes how the MCO responds to changes in the network that affect access and availability of covered services. (9.1 & 9.3) Medicaid: (42 CFR § 438.206) (42 CFR 438.207(c)) and CHIP: (42 CFR § 457.1230(a)) (Attachment 2 and 20) (42 CFR 438.68) (Section 9.4) This includes women's health coverage, family planning, OON coverage and second opinions.	Partially Met	Partially Met	The OON and Emergency Services policy was finalized on March 26, 2024, to include changes ensuring second opinion coverage is provided at no cost to the member, regardless of if the provider is in or out of network. This updated policy was submitted in response to the RFI. The CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy (including the analysis) will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has a Cultural Competency plan that has been submitted to ASES and shared with providers that includes information on how the provider may access the full Cultural Competency plan on the contractor's website. This summary shall also detail how the provider can request a hard copy from the contractor at no charge to the provider. (6.11) (10.3.1.29)	Partially Met	Partially Met	The GHP Cultural Competency policy was finalized on February 29, 2024, to include the process for providers to access the cultural competency plan in various ways. The CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy (including the analysis) will require completion during CY 2024 for submission.

Care Management

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MCO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MCO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple-S CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 27, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Population Health Management
- Care Management Director
- Preventive Management Director
- Preventive Services Supervisor
- Compliance Auditor

Overall Assessment

The CY 2022 EQR identified four findings that required CAP within the Care Management requirement for Triple-S. The first item pertains to how Enrollees can access continued services pursuant to the transition of care process as specified in 42 CFR §438.208 and §438.62 and the MCO contract article 6.1.8. Per the contract, an Enrollee transitioning from one contractor to another has access to services consistent with the access they previously had, and the Enrollee is permitted to retain their current provider for 90 calendar days if that provider is not an in-network provider. The contract also requires Triple-S to refer Enrollees to appropriate network providers to ensure continuity of care. During the CY 2022 review, Mercer was unable to find language describing how Enrollees can access continued services for the transition of care process and recommended that Triple-S revise language in the Beneficiary Manual to include educating Enrollees on how they can access continued services pursuant to the transition of care process.

In response to the CAP, Triple-S stated the Beneficiary Manual is provided by ASES and did not revise the Beneficiary Manual. During the virtual on-site review, Mercer provided technical assistance on the standard and encouraged Triple-S to engage with ASES about updating the Beneficiary Manual. Mercer also discussed using other avenues to inform Enrollees, such as developing a flyer, including information on the Triple-S website, etc.

Triple-S staff informed that they are currently in the process of modifying the Care Management Program Description, HMD-CM-01-2023, to include transition of care information and shared the draft material. Mercer provided feedback on the draft material and recommended Triple-S incorporate all transition of care process requirements in the MCO Contract article 5.5 as the current draft information is not comprehensive.

The second CAP item pertains to the MCO contract article 7.1.6 which requires Triple-S to actively link Enrollees to providers, medical services, residential, social, and other support services by providing health care services through telehealth, telemedicine, and teledentistry. During the CY 2022 review, Mercer was unable to locate language in policy or the handbook describing the availability of healthcare services through telehealth, telemedicine, or teledentistry and recommended Triple-S to develop P&Ps.

In response to the CAP, Triple-S stated it will update P&Ps, HMD-CM-01-2023, *Care Management Program Description & Special Needs Plans*, by June 19, 2024, and submit to ASES for approval. Based on the virtual on-site review, Triple-S shared the revised P&Ps, and Mercer shared that information is not comprehensive and does not to include information on the availability of teledentistry. Regarding member education, Triple-S shared the Consentimiento Informado de Intervenciones Educativas por Telemedicina (Informed Consent for Educational Interventions by Telemedicine) form and stated this document could be used to educate members about the availability of telemedicine. It also stated the Triple-S website informs Enrollees about the availability of telemedicine including teledentistry via Teleconsulta MD. However, the Teleconsulta MD is described as a "virtual consult with physicians" and the review team could not readily find information on the availability of teledentistry.

The third CAP item pertains to the development of a Wellness Plan per the MCO contract articles 12.6.1.2.1-9 and 12.6.1.3 to advance the goals of strengthening Preventive Services, providing integrated physical, BH, and dental services to all Eligible Persons, and educating Enrollees on health and wellness. One of the required elements of the Wellness Plan is an inclusion of a minimum goal of reaching 85% of GHP Enrollees. During the CY 2022 review, Mercer was also unable to locate language describing the measurement strategy for reaching a minimum 85% of all GHP Enrollees in the Triple-S Wellness Program policy and recommended Triple-S develop or revise policy to include strategies for reaching a minimum of 85% of all GHP Enrollees.

In response, Triple-S updated P&P, HEPS-001, in February 2024 by including the language describing the measurement strategy for reaching a minimum 85% of all GHP Enrollees.

The final CAP item is regarding 42 CFR § 438.208(b)(4) requiring MCOs share the results of any identification and assessment of Enrollee's needs with the State or other MCOs serving the Enrollee to prevent duplication of those activities. During the CY 2022 review, Triple-S provided policy outlining the transition process when Enrollees transition from another MCO to Triple-S, however Mercer was unable to identify language describing the Triple-S responsibility to share information with PRMP or other MCOs to prevent duplication.

In response to the CAP, Triple-S indicated they will update its P&P, CPM-002, Enhanced CICU Model, by June 19, 2024. However, during the virtual on-site review, Triple-S informed Mercer that the P&P, CPM-002, Enhanced CICU Model, is not in effect and instead has updated P&P HMD-CM-001, Care Management Program Description & Special Needs Plan. The draft revised P&Ps state that Triple-S will provide data to the new contractor. The CAP will remain unchanged in the 2023 findings since CAP activities were ongoing in 2024

Four CAPs remain open as outstanding items.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Care Management	4	0	4

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that provide: Details and support of an ongoing source of care for Enrollees appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The process for the MCO to provide information to the Enrollee on how to contact their designated person or entity. Coordination efforts P&Ps shall include consultation with Enrollee's PCP. Instructions to Enrollees and Potential Enrollees in the Enrollee Handbook and notices approved by ASES on how to access continued services pursuant to its transition of care process (42 CFR § 438.208) (7.8.2.5) (7.8.2.4.6) (42 CFR § 438.62) (6.1.8 Amendment A)	Partially Met	Partially Met	Triple-S has not updated the Beneficiary Manual or other forms of Enrollee education materials to inform Enrollees about how they can access continued services during transition from another plan. Triple-S is currently in the process of modifying the Care Management Program Description, HMD-CM-01-2023, to include transition of care information. During the virtual on-site review of the policy, the updated information is not comprehensive, and Mercer recommended incorporating all requirements from the MCO contract article 5.5. The CAP will remain unchanged in the 2023 since CAP activities are ongoing in 2024.	Revise the P&Ps, Enrollee Handbook and/or notices to include instructions to Enrollees and potential Enrollees on how to access continued services pursuant to the Triple-S transition of care process. To gain compliance for CY 2024, provide evidence of all training related to the implementation of P&Ps and Enrollee notices, oversight, and monitoring of implementation.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps on: Coordination of Care that actively links the Enrollee to providers, medical services, residential, social, and other support services, including Coordination of Care between MCOs, settings of care and discharge planning for short and long-term hospital and institutional stays, and from community and social support providers. The availability of healthcare services through telehealth, telemedicine, and teledentistry. (42 CFR § 438.208(b)(2)) (7.8.2.3.7) (7.1.6 Amendment M)	Partially Met	Partially Met	Triple-S is currently in the process of modifying the Care Management Program Description to include information on telemedicine. During the virtual on-site review, it appears that information is not comprehensive to include teledentistry. Regarding member education, Triple-S the review team could not readily find information on the availability of teledentistry. Mercer recommended incorporating all requirements for availability of healthcare services through teledentistry in P&Ps.	Develop P&Ps on the availability of healthcare services through telehealth, telemedicine, and teledentistry. To gain compliance for CY 2024, provide evidence of all training and education related to the implementation of P&Ps, oversight, and monitoring of implementation.
The MCO's Wellness Plan includes: A strategy for coordination with government agencies of Puerto Rico integral to disease prevention efforts and education efforts, including the Health Department, the Department of the Family, and the Department of Education. The MCO's Wellness Plan incorporates strategies to reach all Enrollees including those living in remote areas of the	Partially Met	Partially Met	Triple-S updated P&P, HEPS-001, in February 2024 by including the language describing the measurement strategy for reaching a minimum 85% of all GHP Enrollees. The CAP will remain unchanged in the 2023 since CAP activities are ongoing in 2024.	Develop P&Ps on strategy to reach a minimum 85% of Enrollees. To gain compliance for 2024, provide evidence of all training and education related to the implementation of P&Ps, oversight, and monitoring of implementation.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
Contractor's Service Regions. Measurement strategy for reaching at minimum, 85% of GHP Enrollees. Strategy to ensure 85% of pregnant Enrollees receive services under the Pre-Natal and Maternal Program. Strategies for encouraging Enrollees to: Seek annual healthy checkup; appropriately use the services of the GHP, including GHP Service line; seek women's health screenings including mammograms, pap smears, cervical screenings, and test for sexually transmitted infections; maintain a healthy body weight; seek an annual dental exam; Seek BH screening; Attend to the medical and developmental needs of children and adolescents; Receive education regarding the diagnosis and treatment of high-risk diagnosis including: depression; schizophrenia; bipolar disorders; attention deficit disorder and attention deficit hyperactivity disorder; substance abuse and anxiety disorders. (7.5.8.2) (12.5.8.2) (12.6.1.2.1-9) (12.6.1.3)				

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has P&Ps that ensure: that information obtained through identification and assessment of Enrollee needs is shared with the state or other MCOs to prevent duplication, and that each provider maintains and shares Enrollee healthy records. Record sharing is in accordance with HIPAA Privacy and Security standards and as applicable during the care coordination process, all of the Enrollee's information is protected and kept confidential. (42 CFR § 438.208(b)(4-6))(17.7) (17.11) 45 CFR Part 160, 164, subparts A, C and E.	Partially Met	Partially Met	Triple-S has updated its P&P to include language that Triple-S will provide data to the new MCO when Enrollees transition to another MCO. The CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	Develop P&Ps to ensure that information obtained through identification and assessment of Enrollee needs is shared with the State or other MCOs to prevent duplication, and that each provider maintains and shares Enrollee health records. To gain compliance for CY 2024, provide evidence of all training related to the implementation of P&Ps, oversight, and monitoring of implementation.

Utilization Management (UM)

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MCO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MCO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MCO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple-S CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 27, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- Compliance Auditor
- UM Manager
- Facility Based Care Management Director
- Clinical Management Supervisor
- UM Senior Director
- Pharmacy Compliance Analyst
- Pharmacy Regulatory and Compliance Manager
- Pharmacy Senior Manager
- Compliance Auditor
- UM Preauthorization Director

Overall Assessment

To address the requirements for the UM CAP review, Triple-S submitted documentation such as policies and targeted and narrative responses to the outstanding finding from the CY 2022 review.

There was one topic area where follow-up information was requested to meet the standards. Within the desk review submission, Triple-S responded to the item, and this information, combined with the virtual review provided evidence of fully meeting the standard.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Utilization Management (UM)	1	1	0

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO has written P&Ps that reflect timeliness requirements applicable to prior authorization decisions: (i) the MCO provides a decision no more than 72 hours from the time of the service authorization request for all covered services unless the MCO or Enrollee's provider determine that the Enrollee's life or health could be endangered by a delay in accessing services, in which case the decision must be provided as expeditiously as the Enrollee's health requires but no later than 24 hours from the service authorization request; (ii) the circumstances in which ASES may grant an	Partially Met	Met	All requirements of this metric have been met through the RFI document and other submissions. Outstanding questions were clarified during the virtual on-site presentation.	None

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
extension of the decision timeframe for up to 14 calendar days (11.4.2.1.2); and requirement to provide the Enrollee with a written notice of the reason for the extension and right to file a grievance if the Enrollee disagrees with the decision. (11.4.2.1.3) (42 CFR § 438.210(d)) Section 11.4.2				

Grievance and Appeals (G&A)

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MCO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MCO must inform members of how to access the grievance system, the availability of the MCO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MCO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MCO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MCO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MCO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MCO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MCO must keep a log of all G&As filed. The MCO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the MCO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple-S CAP items and supporting documentation. This review was conducted based on information submitted by the MCO through the RFI and through virtual on-site meetings held June 27, 2024. The virtual on-site meetings involved participation from MCO key leadership including, but not limited to:

- QI Medical Director
- G&A Manager
- G&A Supervisor
- Compliance Auditor
- Quality & Efficiency Analyst

Overall Assessment

The CY 2022 EQR identified two findings that required a CAP within the G&A requirements for Triple-S. The first item pertains to the Enrollee's ability to file an appeal either orally or in writing per the MCO contract articles 14.5.2 and 14.5.4. During the CY 2022 review, Mercer noted that Triple-S required verbal appeals filed by the Enrollee must be followed by a written appeal within 10 days of the verbal request and recommended Triple-S to review and update P&Ps, the provider manual, and MCO process flow chart to align with the contract and federal regulations.

In response to the CAP, Triple-S revised P&Ps, PSG Admin 3 2017, on June 19, 2024. As of the virtual on-site review, P&Ps are with the Compliance Department for review and approval. During the virtual on-site review, Triple-S shared the revised 2024 Provider Guidelines, updated in March 2024. Mercer recommended Triple-S review and further revise the Provider Guideline to include information on the Enrollee's ability to file appeals verbally.

The second CAP item pertains to the content of the Written Notice of Disposition of an Appeal. 42 CFR §438.408 and the MCO contract articles 14.5.9, 14.5.14, and 14.5.15 contain a list of minimum requirements to include, but not limited to, the date of the appeal's resolution. During the CY 2022 review, Mercer noted that the appeal resolution date is not included in the template and recommended Triple-S update the template to comply with the requirement.

In response to the CAP, Triple-S sent an email to staff on November 15, 2023, regarding the EQR audit finding and instructed staff to include the appeal decision date in the appeal disposition letter. However, neither appeal approval nor denial letter templates have been updated to include the date of the appeal resolution.

Both CAPs remain open as outstanding items.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Grievance and Appeals (G&A)	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 calendar days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal within 10 calendar days. (42 CFR §438.402 (2)(ii)) (14.3.3, 14.5.2, 14.5.4)	Partially Met	Partially Met	Per the CAP, Triple-S has revised P&Ps, PSG Admin 3 2017, on June 19, 2024, and P&Ps are currently with the Compliance Department for review and approval. Triple-S plans to submit P&Ps to ASES for approval. Triple-S has shared the revised 2024 Provider Guideline which was updated in March 2024; however, the revised language did not contain information on the Enrollee's ability to file appeals verbally. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Review and update MCO P&Ps, provider manual, and MCO process flow chart to align with the contract and federal regulations. Provide any necessary staff training, standard operating procedures, or job aids related to changes made. To gain compliance for CY 2024, provide evidence of all training related to the implementation of P&Ps, oversight, and monitoring of implementation.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MCO's P&Ps clearly state time frames for standard resolution of appeals and notification of the decision within 30 calendar days. (42 CFR §438.408) Written Notice of Disposition of an appeal is provided to the Enrollee within two business days of the decision. (14.5.9, 14.5.14 and 14.5.15)	Partially Met	Partially Met	Triple-S has sent an email to staff on November 15, 2023, regarding an EQO audit finding about including the appeal decision date in the appeal disposition letter. However, appeal approval and denial letter templates have not been updated to include the date of the appeal resolution. CAP will remain unchanged in the 2023.	Update the member appeal disposition letter template to include the date the appeal was reviewed and decision was made to align with section 14.5.15 of the contract. To gain compliance for 2024, update appeal decision and denial templates to include the date of the appeal resolution and provide evidence of all training related to the implementation of letters, P&Ps, oversight, and monitoring of implementation.

Quality Improvement and Assessment

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MCO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330 (b–e).

The intent of this regulation is to ensure the MCO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Findings

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Quality Improvement and Assessment	0	0	0

Triple-S did not have CAP items in this area from the CY 2022 EQRO review.

Appendix B

Review of Compliance with Medicaid Managed Care Regulations for MAOs

Introduction

To complete the CAP review of compliance with Medicaid managed care regulations, Mercer utilized the mandatory compliance validation protocol (Protocol 3) to determine the extent to which MAOs comply with federal standards set forth in 42 CFR 438, part 56, 100, 114, Subparts D and QAPI, state standards, and MAO contract requirements. Below is a crosswalk of the standards reviewed by the EQRO.

Standard Reviewed by the EQRO	Subpart D and QAPI Standard
Enrollee Rights and Protections	§438.56 Disenrollment requirements and limitations
	§438.100 Enrollee rights requirements
Provider Network	§438.206 Availability of Services
	§438.207 Assurances of Adequate Capacity of Services
	§438.214 Provider Selection
	§438.230 Sub-contractual Relationships and Delegation
Care Management	§438.208 Coordination and Continuity of Care
	§438.224 Confidentiality
Utilization Management (UM)	§438.210 Coverage and Authorization of Services
	§438.114 Emergency and post-stabilization services
	§438.236 Practice Guidelines
Grievance and Appeals (G&A)	§438.228 Grievance and Appeal Systems
Quality Improvement and Assessment	§438.242 Health Information Systems
	§438.330 QAPI

Humana

Administration and Organization

Process and Documentation Reviewed

Mercer conducted a desk review of submitted documentation as well as a virtual on-site meeting held June 3, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Regional VP of Operations
- Associate VP of Compliance
- Associate Director of Compliance
- Senior Compliance Professional
- Compliance Lead

Organizational Structure

Humana manages a Medicare Advantage line of business in Puerto Rico. The plan serves approximately 15,800 Platino members (out of a total Medicare membership of approximately 31,600 members).

Humana's headquarters are located in Louisville, Kentucky. The plan operates Puerto Rico based service centers in Hato Rey, Caguas, Humacao, Ponce, Mayaguez, and Barceloneta where customer care specialists assist members with inquiries related to benefits, eligibility, referrals, pre-authorization status, plan documents, duplicate ID Cards, and certifications. All service centers operate during regular business hours of 8:00 am to 5:00 pm, Monday through Friday.

Humana's organizational and reporting structure has not changed since the last review and there have been no key leadership changes. Humana Platino is led by a corporate board of directors which provides oversight of Humana's executive leadership team. The President and CEO oversees the Regional VP of Operations who, in turn, oversees Service Operations. The Service Operations includes key departments serving Humana Platino Enrollees including the Quality Department (including the Audits Division and the call center), Claims Processing (including provider contracting, credentialing, and re-credentialing), Consumer Service Operations (including Enrollee enrollment, G&A, and Enrollee service centers) and Business Support Coordination (providing general administrative support to the organization). The Clinical Operations is led by the Regional VP of Health Services/CMO and includes UM, quality management, clinical programs, pharmacy, and care management. Humana Platino currently employs approximately 600 associates who support the Medicare Advantage LOB. Humana does not dedicate staff solely to this health plan in Puerto Rico, but all Humana staff are cross trained on the plan's LOBs.

Delegated Entities

Humana Platino delegates responsibilities to eight different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare of Puerto Rico, Inc. (APS)	Mental Health (MH) Services—MH benefits, MH provider network credentialing and re-credentialing, MH claims processing and payment, pharmacy services, MH quality and UM services, BH care management, MH and pharmacy G&A, MH education, reporting, and MH Enrollee and provider call center.
Argus Dental and Vision	Vision Services—claims adjudication, credentialing, and re-credentialing.
Inovalon	Network Services—credentialing and re-credentialing services.
Luxottica of America (dba EyeMed Vision Care)	Vision Services—claims adjudication for routine vision services.
Net Claims Solution	Dental Services—claims processing, direct Enrollees reimbursements, and dental preservice platform.
Oncology Analytics (dba OncoHealth)	Oncology-related UM approvals.
Telecontacto	Call Center Services—auditing of data submitted by Operational Risk Management to review compliance with CMS, state, and Medicaid requirements.
Therapy Network of Puerto Rico (TNPR) – also known as HN1 (Health Network One)	Physical, Occupational and Speech Therapy—contracting, credentialing, and re-credentialing of providers, providers call center, pre-service organization determinations, and claims processing.

Humana has P&Ps in place operationalizing the auditing, oversight, and monitoring of delegated entities. These policies describe audit and corrective action procedures, preserving Protected Health Information and requirements pertaining to sub-delegation.

Accreditation

Humana Platino does not hold accreditations; however, some of their delegate entities hold accreditations. APS holds a URAC accreditation for credentialing and UM (expiration September 2025) and Oncology Analytics (dba Oncohealth) holds a NCQA UM accreditation (expiration February 2026).

Employee Training

All Humana Platino associates, contractors, delegates, and sub-delegates are required to receive training on advance directives, cultural competency, fraud, waste, and abuse (FWA), HIPAA and Enrollee rights. Call center staff are trained on G&A. Humana Platino reports that all vendors must complete the Humana Privacy and Humana Ethics training annually, as provided by Humana. All trainings are provided to new hires, annually or as needed depending on roles and most are delivered virtually.

Enrollee Rights and Protections

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MAO complies with the State enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MAO has written policies related to Enrollee rights and ensure the MAO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable state and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MAO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MAO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MAO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MAO maintains P&Ps related to advance directives, including their rights under state law, and must contain clear and concise language on the limitation if the MAO cannot implement an advance directive as a matter of conscience. The MAO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the state laws. The MAO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate Humana's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through a virtual on-site meeting held June 3, 2024. The virtual on-site meeting involved participation from MAO key leadership including, but not limited to:

- Director of Provider Engagement
- Senior Compliance Professional
- Associate VP of Compliance
- Associate Director of Compliance
- Manager, Provider Engagement
- Compliance Lead
- Regional VP of Operations
- G&A Supervisor

Overall Assessment

For Enrollee services, Humana had one open CAP item from 2022 pertaining to processes for providers to follow when a provider issues a moral and religious objection and then elects not to provide, not to reimburse for, or not to provide a Referral or Prior Authorization for a service within the scope of the detailed covered services. During the virtual review, Humana does not currently have a process in place to achieve compliance with this contractual requirement. As such, this CAP item will remain open. To achieve compliance with this requirement, it is recommended that Humana develop P&Ps, amend the provider guidelines and/or provider contracts to include the required processes and notification requirements for provider denials based on moral or religious objections.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Enrollee Rights and Responsibilities	1	0	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place to ensure: (5.5.1-5.5.3) If, during the course of the Contract period, pursuant to 42 CFR 438.102, the contractor elects not to provide, not to reimburse for, or not to provide a Referral or Prior Authorization for a service within the scope of the detailed covered services, because of an objection on moral or religious grounds, the contractor shall notify ASES within 120 calendar days before adopting the policy with respect to any service; Enrollees within 90 calendar days after adopting the policy with respect to any service; and Enrollees before and during Enrollment. The contractor shall furnish information about the services it does not cover based on a moral or religious objection to ASES.	Not Met	Not Met	Humana does not currently have a process in place to achieve compliance with this contractual requirement. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Submit any applicable P&Ps, amendments to the provider contract, or revised provider guidelines outlining processes for moral and religious objections including the process for the provider to notify the Plan, the member, and ASES of the decision. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Provider Network

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MAO participates in the state's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MAO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MAO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MAO has written P&Ps for the selection and retention of providers and a documented process for the initial and re-credentialing of providers. Regulation 438.214(c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214(d) prohibits the MAO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with state requirements. The MAO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MAO has P&Ps in place which guarantee the MAO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MAO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MAO obtains state approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 3, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Director of Provider Engagement
- Manager of Provider Engagement
- Senior Compliance Professional
- Compliance Lead
- AVP of Compliance

Overall Assessment

To meet the requirements for the CAP review, Humana submitted documentation such as trainings and the annual network development and management plan as well as targeted responses to the outstanding finding from the CY 2022 comprehensive review. There were no new P&Ps developed since the prior 2022 EQR review. There were three topic areas where follow up information was requested to meet the standards.

The following three CAP items required further action and had been scored as partially met from the CY 2022 comprehensive review:

- The information provided in the Explanation of Coverage (EOC) regarding second opinion indicates that Enrollees are entitled to seek second opinion from another network provider before undergoing surgery. The development of these P&Ps will ensure Enrollees make well-informed health care decisions and improve treatment outcomes. This did not include a broader range of medical services, besides surgical procedures.
- During the 2024 CAP review, Humana provided documentation within the Provider Manual providing evidence that second opinions are covered more broadly than what was found during the 2023 comprehensive review. The expanded description is as follows: Humana will pay and cover a member who chooses to get a second opinion from a qualified health care professional. A member has the right to a second medical opinion, in any case, that the member questions reasonableness, necessity or lack of necessity by surgical procedures, treatment for a serious injury or illness. The revision date for the Provider Manual is April 30, 2024. As the revision occurred in 2024, the CAP item will remain open for the CY 2023 review period.
- The provider directory did not include an indicator for completion of Cultural Competency training as required in contract citation 4.3.1.1. Humana provided a plan to track, trend, and flag providers who have completed Cultural Competency training and develop the indicator in the provider directory. The targeted completion is December 31, 2024.

The Humana Provider Manual offers comprehensive information aligning for most of the contractual provider guideline requirements. The requirements that are required but not present during the comprehensive review include:

- Electronic health records and sanctions or fines applicable in cases of non-compliance, and FWA compliance
- Evidence of delivering the provider guidelines to providers within 15 days of contracting
- Report requirements
- UM P&Ps
- Medical Record maintenance requirements

Humana updated the Humana Puerto Rico Network Management Program Description to include:

- Evidence of delivering the provider guidelines to providers within 15 days of contracting through new provider orientation which includes distribution of the Provider Manual
- Authorization and referral processes which fulfills the requirement for UM P&Ps
- Report requirements
- Provider Violations and Dispute Resolution which fulfills the requirement for sanctions or fines applicable in cases of non-compliance, and FWA compliance

Two outstanding items that are required within contract citation 7.1.4, are on electronic health records and review of Medical Record Maintenance requirements.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Provider Network	3	0	3

During the on-site virtual review, Humana confirmed that the four delegated entities specific to Provider Network tasks have not changed. Humana delegates provider network services as outlined in the table below.

Delegated Entity	Type of Entity and Services
APS Healthcare Puerto Rico, Inc.	BH network management activities, including contracting and credentialing services.
Argus Dental and Vision	Credentialing and re-credentialing services.

Delegated Entity	Type of Entity and Services
Inovalon, Inc.	Credentialing and re-credentialing services.
Therapy Network of Puerto Rico (TNPR) – also known as HN1 (Health Network One)	Physical, Occupational, and Speech provider contracting and credentialing.

The table below outlines an overview of the MAO network.

Provider Type	Number of Providers in CY 2023
Primary Care Physician (PCP) (total)	2,857
Adult	Not Reported
Pediatric	143
Primary Medical Groups (PMG)	9
Obstetrics and Gynecology (OB/GYN) Providers	445
Hospital	55
FQHC	4
Urgent Care	24
Nursing Facility	4
Adult and Pediatric Dental Providers	601
Vision	397
Adult High Volume Specialty Care Providers (total)	4,100
Cardiology	332
Endocrinology	127
Oncology	173
Nephrology	154
Pulmonology	137

Provider Type	Number of Providers in CY 2023
Pediatric High Volume Specialty Care Providers (total)	Not Reported
Cardiology	332
Endocrinology	127
Oncology	Not Reported
Pulmonology	173
Speech, Language, and Hearing	137
Psychiatric Hospitals	126
Psychiatric Partial Hospitals	9
Adult and Pediatric Mental Health Providers (Psychologist, Psychiatrist, Licensed Clinical Social Worker, and/or Licensed Professional Counselor)	999
SUD Inpatient Detoxification and/or Rehabilitation	Not Reported
SUD Intensive Outpatient (IOP) and/or Partial Hospitalization Provider (PHP)	Not Reported
Addiction Medicine/Withdrawal Management Provider	Not Reported

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place aligning with:(42 CFR § 438.206) (42 CFR 438.207(c)) (6.1.1- 6.1.2) establish and maintain a network of Network Providers that complies with 42 CFR 438.206(b)(l) and is otherwise sufficient to provide adequate access to covered services to meet the needs of Enrollees in the Medicare Platino Plan. This must include a women's health specialist to provide women's routine and preventive healthcare services, Ability to obtain a second opinion, in or outside the network, at no cost to the Enrollee. Adequate and timely access and coverage for Network Providers as well as out of network services if contractor is unable to provide such access.	Partially Met	Partially Met	Humana provided documentation within the Provider Manual providing evidence that second opinions are covered more broadly than what was found during the 2023 comprehensive review. The expanded description is as follows: Humana will pay and cover a member who chooses to get a second opinion from a qualified health care professional. A member has the right to a second medical opinion, in any case, that the member questions reasonableness, necessity or lack of necessity by surgical procedures, treatment for a serious injury or illness. The revision date for the provider manual is April 30, 2024. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place and a (4.3.1.1–4.2.1.2) Provider Directory with the names of physicians, including specialists, hospitals, pharmacies, behavioral health providers, covered under this contract, along with their provider group affiliations, locations, office hours, telephone numbers, websites, cultural and linguistic capabilities, completion of Cultural Competency training, and accommodations for people with physical disabilities of current Network Providers. The Provider Directory shall also identify all Network Providers that are not accepting new patients.	Partially Met	Partially Met	Humana provided a plan to track, trend and flag providers who have completed the Cultural Competency training and develop the indicator in the provider directory. The targeted completion is December 31, 2024. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Finalize and submit the procedure to track providers who have completed the Cultural Competency training and submit verification of the indicator in the directory. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.
The MAO has Provider Guidelines in place and P&Ps to ensure: (7.1.1–7.1.6) The contractor shall prepare Provider Guidelines, to be distributed to all Network Providers. The Provider Guidelines shall, in accordance with 42 CFR 438.236, (i) be based on valid and reliable clinical evidence or a consensus of providers in the particular field; (ii) consider	Partially Met	Partially Met	Humana provided documentation within the Provider Manual as supporting documentation of Humana's provider guidelines. The revision date for the Provider Manual is April 30, 2024. Humana updated the Humana Puerto Rico Program Description to	Update the Humana Puerto Rico Program Description to include the following per contract citation 7.1.4, electronic health records and Medical Record maintenance requirements or provide the English translation of these contractual requirements within

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
the needs of the contractor's Enrollees; (iii) be adopted in consultation with providers; and (iv) be reviewed and updated periodically, as appropriate.			include the evidence of delivering the provider guidelines to providers within 15 days of contracting, report requirements, fines applicable in cases of non-compliance, and FWA compliance and UM P&Ps. The updated description did not include information on electronic health records nor Medical Record Maintenance requirements. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	the Humana Provider Manual. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Care Management

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MAO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Care Management	0	0	0

Findings

The MAO did not have CAP items in this area from the CY 2022 EQRO review.

Utilization Management (UM)

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MAO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MAO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MAO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 3, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Regional VP of Health Services
- Associate Director of UM
- Associate VP of Compliance
- Senior Compliance Professional Lead
- Senior Performance Officer
- Compliance Lead

Overall Assessment

To address the requirements for the UM CAP review, Humana submitted documentation such as policies and targeted narrative responses to the outstanding findings from the CY 2022 comprehensive review.

There were four topic areas where follow-up information was requested to meet the standards. Within the desk review submission, Humana responded to each item, however the topic areas remained “Partially Met”, as Humana has reported a CAP but the final documents providing evidence of the planned changes remain outstanding or additional questions remained.

The following four CAP items required further action and had been scored as “Partially Met” from the CY 2022 comprehensive review.

- Humana did not have a formal documented process to ensure compliance with prior authorization requirements for parity in MH and SUD benefits.
- Humana did not provide a plan to define, detect, monitor, and intervene for over- and under-utilization.
- Humana did not provide written documentation prohibiting the MAO or any delegated UM agent from incentivizing UM decisions as per contractual and CFR requirements.
- Humana provided a policy that included language that emergency services do not require prior authorization, but the policy did not include documentation to demonstrate compliance with the requirement that post stabilization is covered and the Enrollee is not liable for any post-stabilization treatment.
- Humana submitted the following documents to address the CAP:
- HUM-HCO UM Mental Health Parity – Compliance Monitoring Plan – PR Draft dated 02/02/2024
- HUM-HCO 01-031 Post-Stabilization Services last revised 10/10/2023
- Utilization Management Concurrent Hospital Review_V20 last revised 10/25/2023
- UM Program Description approved 02/13/2024
- RFI response

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Utilization Management	4	2	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has written P&Ps that: (i) identify, define, and specify the amount, duration, and scope of covered services available under the contract and how and where to access such services; (42 CFR § 438.10. Platino section 4.3.1.2). The MAO has P&Ps to ensure its prior authorization requirements comply with the requirements for parity in MH and SUD benefits under 42 CFR § 438.910(d) (Platino 5.3.9.2).	Partially Met	Partially Met	The CAP request was to develop a P&P that outlined the MAO process to ensure authorization requirements to comply with parity requirements. Humana submitted a draft policy (dated 02/02/2024) for UM Mental Health Parity Compliance Monitoring Plan. The policy indicates that Humana complies with all federal requirements contained in the MHPAEA and any changes that could affect compliance will be communicated quarterly and annually. Humana reports that the policy was approved by the UMC on March 26, 2024, and a meeting is scheduled June 17 to begin planning the parity evaluation with multiple departments (UM, Risk Management, Compliance) and APS. Staff have been informed of the new	Continue to implement the parity analysis plan. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy (including the analysis) will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
			policy through an established process. Staff are responsible for reading and acknowledging the content. The acknowledgements are tracked. Humana provided an acknowledgement sample for this policy. CAP remains unchanged in 2023 findings since CAP activities are ongoing in 2024.	
The MAO has written UM P&Ps to assist Enrollees and providers to ensure appropriate utilization of resources. The MAO's P&Ps reflect the subcomponents listed under 8.2.1 of the Platino contract (42 CFR § 438.210(a)(3 and 4) and 42 CFR § 438.210(b)).	Partially Met	Partially Met	The CAP request was to submit a policy that outlines the process for defining, detecting, monitoring, and intervening for over and underutilization. Humana submitted a UM Program Description with Section VIII highlighted as describing program monitoring, evaluation and trending analyses including over and underutilization. The language in the program description did not address the process for monitoring over-	Develop or submit a policy that outlines the process for monitoring over- and under-utilization. Ensure that staff are trained in the policy and oversight and monitoring are in place. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
			and under-utilization. Humana reports that monitoring is in place and performs a weekly review of inpatient, outpatient, medications, and other services. Findings are reported yearly to the Quality Improvement Committee (QIC). Humana submitted an example of a report that included data and analysis. The CAP remains unchanged in the 2023 findings as CAP activities are ongoing in 2024.	
The MAO has written P&Ps that prohibit the MAO or any delegated UM agent from providing compensation or anything of value to its employees, agents, or contractors based on: either a percentage of the amount by which a claim is reduced for the payment or the number of claims or the cost of services for the denied authorization or payment; or any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary covered service to any Enrollee (Platino	Partially Met	Met	The CAP request was for a policy that included language prohibiting the MAO or delegated entity from incentivizing UM decisions. Humana submitted a revised policy HGOCHR09-0819 Utilization Management Concurrent Hospital Review_V20 (revised 10/25/23) which included the required language. Staff review this policy through the	Continue to ensure staff are trained on the requirement and monitor that policy is being followed.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
8.2.4) (42 CFR § 438.210(e)).			established acknowledgement process. Humana submitted an updated Program Description (approved 2/13/2024) that includes language that the program is not structured to provide inappropriate incentives, for denials, limitations, and discontinuation of authorized services. The information is also included in the annual Ethic and Compliance Training. Humana provided a screenshot of the required language and the attestation for the ethics training. The CAP is closed as Humana approved the policy in CY 2023 and trained staff on the update. Training is also ongoing through annual compliance and ethics training.	

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has written P&Ps that reflect that: (i) emergency services do not require a Referral or Prior Authorization, (ii) the MAO covers post-stabilization services consistent with the requirements in 5.3 of the contract; and (iii) the Enrollee treated for an emergency medical condition or psychiatric emergency shall not be held liable for any subsequent screening or treatment necessary to stabilize the Enrollee (42 CFR § 438.114) (Platino 8.6; 5.3).	Partially Met	Met	The CAP request was to develop a policy that reflects that post stabilization services are covered, and that the Enrollee is not liable for any post stabilization treatment. Humana provided a policy HUM-HCO01-031 Post Stabilization Services (revised 10/10/2023) that reflected that the MAO covers post-stabilization services. Staff were trained on the policy through the established acknowledgement process. Humana provided EOC that explains to members that they are entitled to follow-up care after an emergency and that care will be covered by the plan. The CAP is closed as the policy was developed and trained in CY 2023.	N/A

Grievance and Appeals (G&A)

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MAO must inform members of how to access the grievance system, the availability of the MAO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MAO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MAO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MAO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MAO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MAO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MAO must keep a log of all G&As filed. The MAO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate Humana's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Humana's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 3, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Regional VP of Operations
- Associate VP of Compliance
- Associate Director of Compliance
- Senior Compliance Professional
- Senior Compliance Professional
- Compliance Lead of Compliance
- Director of G&A
- Supervisor of G&A

Overall Assessment

The CY 2022 EQR identified six findings that required CAP within the G&A requirements for Humana 42 CFR part 422 Subpart M, 42 CFR Part 438, Subpart F, and Platino contract article 11.1.2 require Humana to have an integrated G&A system that includes Complaint, Grievance, Service Authorization Requests, Appeal, and access to the Administrative Law Hearing processes. While Humana has an integrated G&A system, it lacked inclusion of Complaints. 42 CFR §438.402 (2)(ii)) and Platino 11.5 allow an Enrollee to file an appeal orally and in writing. However, Humana's P&Ps state that oral appeals are allowed for "only for reasons of illiteracy, handicap, or if the member is too ill to write." Platino contract article 11.5.13 requires Humana to provide a copy of the written Notice of Disposition to ASES within two business days of the resolution, and Humana did not have a process in place. 42 CFR §438.420(d) and Platino contract article11.7.4 state that Humana may not recover the cost of the services furnished to the Enrollee while the Appeal or Administrative Law Hearing was pending from the Enrollee, and Humana did not have P&Ps in place. 42 CFR. § 438.424 and Platino contract article 11.7.5 require to have in place how an overturned appeal is managed along with timelines, and the timeline for providing disputed services when the pending decision were reverse was not included in P&Ps. Lastly, 42 CFR §438.408(f), Act 72 of September 7, 1993, and Platino contract article 11.6.1 require Humana to explain the Enrollee rights to and the procedures for an Administrative Law Hearing (ALH), and Humana's P&Ps did not include notification or timeline requirements.

In response to these findings, Humana developed a CAP in CY 2024. For the first two items, 42 CFR part 422 Subpart M, 42 CFR Part 438, Subpart F, and Platino contract article 11.1.2 and 42 CFR §438.402 (2)(ii) and Platino 11.5, Humana's CAP stated the existing P&Ps have these requirements in place, and therefore, no further action is taken. During the virtual on-site review, Humana informed that it has updated P&Ps on April 12, 2024, and Mercer

provided technical assistance as P&Ps contained inconsistent language about an Enrollee's ability to file an appeal orally. Also discussed was incorporating Complaints as part of an integrated G&A system per Platino contract article 11.1.2. Following the virtual on-site review, Mercer reviewed the revised P&Ps. It is noted that Humana clarified inconsistent language regarding an Enrollee's ability to file an appeal orally. Revised P&Ps state that an Enrollee may file a complaint, grievance, or appeal, and all cases are referred to the G&A Department. Revised P&Ps still do not address the timeframes associated with filing and resolving a complaint as well as treating complaint as a grievance when the complaint is not resolved within the timeframe in accordance with the Platino contract article 11. CAP will remain unchanged as Humana P&Ps must support contract requirements outlined in article 11.

Regarding a process of notifying ASES within two days of an appeal decision per Platino contract article 11.5.13, Humana's CAP response stated that the G&A department will send the appeal decision to the Humana Regulatory Compliance Team to send the notices to ASES. However, during the virtual on-site review Humana has revealed that the process is not in place as they have not received instructions from ASES and plans to follow up with ASES.

P&Ps revised in 2024 also contains language that Humana will not cover from the Enrollee for services that were furnished while an appeal/ALH is pending per 42 CFR §438.420(d) and Platino contract article 11.7.4 and the timeline for effectuation of an overturned appeal per 42 CFR § 438.424 and Platino contract article 11.7.5.

Lastly, regarding the Enrollee right to and procedures for an Administrative Law Hearing, Humana has revised P&Ps to state that "member should also be informed of Medicaid appeal rights through ASL and ASES". Since this is an Enrollee right, it is recommended that Humana revise P&Ps to state "must" instead of "should" and include the procedure in addition to the Enrollee's right.

Out of six CAP items identified, all six items remain open as outstanding items in the CY 2023 findings since CAP activities occurred in CY 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Grievance and Appeals (G&A)	6	0	6

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has a written grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The grievance system includes a complaint process, grievance process, appeal process, and access to the Administrative Law Hearing (ALH) process. (42 CFR part 422 Subpart M) (42 CFR Part 438, Subpart F) Platino article 11.1, 11.1.2	Partially Met	Partially Met	Humana provided revised P&Ps with the revision date of April 12, 2024. Revised P&Ps state that an Enrollee may file a complaint, grievance, or appeal, and all cases are referred to the G&A department. However, P&Ps do not address the timeframes associated with filing and resolving a complaint as well as treating complaint as a grievance when the complaint is not resolved within the timeframe in accordance with the Platino contract article 11. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Develop P&Ps to support contract requirements outlined in article 11, including appropriate definitions for, and tracking and trending of complaint, grievance, and appeals data. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal orally or in writing within 60 calendar days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal. The contractor shall acknowledge receipt of each appeal in writing within 10 business days. (42 CFR §438.402 (2)(ii)) (Platino 11.5)	Partially Met	Partially Met	Humana provided revised P&Ps with the revision date of April 12, 2024. Updated P&Ps state that an Enrollee can file an appeal verbally or in writing and contains the timeframe for acknowledge receipt of an appeal. CAP will remain unchanged in the CY 2023 findings since CAP activities occurred in 2024.	Review and revise G&A P&Ps and Enrollee materials to ensure Enrollees can file an appeal verbally or in writing and that all appeals are acknowledged in writing within 10 business days. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.
The MAO's P&Ps clearly state time frames for standard resolution of appeals and notification of the decision within 30 calendar days. (42 CFR §438.408) Written Notice of Disposition of an appeal is provided to the Enrollee and ASES within two business days of the decision. (Section 11.5.10.1 and 11.5.13)	Partially Met	Partially Met	Humana staff informed during the virtual on-site review that the process is not in place as they have not received instructions from ASES on how to submit copies of the written Notice of Disposition to ASES, and it plans to follow up with ASES. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Develop a process for notifying ASES of appeal decisions and include in P&Ps revision or standard operating procedure. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO's P&Ps define when and how the MAO may uphold a denial and recover the cost as applicable for services furnished while the appeal/ALH was pending. (42 CFR §438.420(d)) (Platino 11.7.4)	Not Met	Not Met	Humana provided revised P&Ps with the revision date of April 12, 2024. Updated P&Ps state that Humana will not cover from the Enrollee for services that were furnished while an appeal/ALH is pending. CAP will remain unchanged in the CY 2023 findings since CAP activities occurred in 2024.	Develop a P&P that states the MAO will not recover costs from the Enrollee for services that were furnished while an appeal/ALH is pending. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.
The MAO's P&Ps clearly defines how the MAO may reverse a denial and promptly authorize or provide the disputed services that were not furnished during the appeal process; and, that the MAO will pay for services received during the dispute. (Platino 11.7.5 and 11.7.6) (42 CFR § 438.424)	Partially Met	Partially Met	Humana provided revised P&Ps with the revision date of April 12, 2024. Updated P&Ps include the timeline for effectuation of an overturned appeal. CAP will remain unchanged in the CY 2023 findings since CAP activities occurred in 2024.	Update P&Ps to reflect the timeline for effectuation of an overturned appeal. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO's P&Ps explain the process to inform the Enrollee of their right to and procedures for requesting an ALH. (GHP 14.6) (42 CFR §438.408(f)) (Act 72 of September 7, 1993) (11.6.1)	Partially Met	Partially Met	Humana provided revised P&Ps with the revision date of April 12, 2024. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Update P&Ps and Enrollee materials to include appropriate language to ensure Enrollee rights and procedures to request an ALH according to 11.6.1 of the Platino contract. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Quality Improvement and Assessment

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330 (b–e).

The intent of this regulation is to ensure the MAO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Findings

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Quality Improvement and Assessment	0	0	0

Humana did not have CAP items in this area from the CY 2022 EQRO review.

MCS

Administration and Organization

Process and Documentation Reviewed

Mercer conducted a desk review of submitted documentation as well as a virtual on-site meeting held June 4, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Senior Vice President (SVP), Clinical Affairs
- SVP of Operations
- CMO
- AVP of Enrollment
- AVP of Audit and Marketing
- VP of Contracting and Credentialing
- Director of Compliance
- Director of UM

Organizational Structure

MCS Advantage is a Medicare advantage plan. MCS's organizational structure includes a corporate board of directors which provides oversight to the audit, compliance, investments, independent directors, and compensation committees. Organizational charts reflect the reporting and departmental structure. The CEO oversees a team of VP, SVP, and C suite positions, who, in turn, oversee the following departments: Enrollee Services, Quality, Provider Operations, Pharmacy, Clinical Operations, UM, Network Management, Clinical Affairs, and Customer Service. As of December 2023, MCS had a total of 2,191 staff. This represents a reduction of about 170 positions since December 2022. MCS reports the this is largely due to staff resignations, and they currently have 100–120 vacancies. Departments such as Customer Service and Sales typically have higher turnover than other departments. All areas have continency plans to ensure operations are fully covered and there has not been an operational impact. MCS did not report any changes in department or reporting structures during 2023. MCS appears to have a growing membership, with enrollment rates of 210,313 in December of 2023. In 2024, membership was reported as 257,928 in January, 264,892 in February, and 268,803 in March.

MCS's headquarters are located in San Juan, Puerto Rico. The plan has 12 service centers located throughout the island where Enrollees and their representatives are offered direct access to services such as benefit inquiries, prior authorization requests, grievance or complaint filing, PCP changes, premium payments, material requests and other things. Medicare Advantage prospects can learn about the plan as well. Eleven of the service

centers are open Monday through Friday from 8:00 am to 5:00 pm. One site is open seven days a week from 9:00 am to 7:00 pm Monday through Saturday and 11:00 am to 5:00 pm on Sunday.

Delegated Entities

MCS delegates responsibilities to six different entities outlined in the table below.

Delegated Entity	Type of Entity and Services
Elixir	Pharmacy Benefit Services
Eye Management of Puerto Rico	Vision Services – contracting, credentialing, and re-credentialing of optometry providers, providers, call center, and vision claims processing.
Episouce	Encounter Data Submission
First Health Care (FHC) Health System of Puerto Rico	Mental Health (MH) Provider Services – contracting, credentialing, and re-credentialing of MH providers, provider and Enrollees' call centers, pre-service organization determinations, and appeals.
Net Claims Solution	Dental Management Services – claims processing, direct Enrollees reimbursements, dental pre-service platform.
Therapy Network of Puerto Rico (TNPR) – also known as HN1 (Health Network One)	Physical, Occupational, and Speech Services – provider contracting, and credentialing and re-credentialing of providers, providers call center, pre-service organization determinations and claims processing.

Accreditation

Health Plan accreditation is not a contract requirement. MCS has a full three-year accreditation with Accreditation Association for Ambulatory Health Care (AAAHC) effective June 28, 2021. Re-accreditation is planned for June 2024.

Employee Training

All staff are provided with a comprehensive Training Plan. All new associates complete training on advance directives, grievances and appeals, cultural competency, FWA, HIPAA, sexual harassment and domestic violence protocols. Annually thereafter, employees receive training on advance directives, FWA, prevention and detection of financial exploitation,

cultural competency, and HIPAA. Other trainings are dependent on specific positions and department. Training for all new hires and annual trainings are tracked and reported.

Enrollee Rights and Protections

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MAO complies with the state enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MAO has written policies related to Enrollee rights and ensure the MAO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable state and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MAO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MAO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MAO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MAO maintains P&Ps related to advance directives, including their rights under state law, and must contain clear and concise language on the limitation if the MAO cannot implement an advance directive as a matter of conscience. The MAO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the state laws. The MAO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate MCS's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through a virtual on-site meeting held June 4, 2024. The virtual on-site meeting involved participation from MAO key leadership including, but not limited to:

- VP of Contracting and Credentialing
- Customer Service
- VP of Enrollment
- VP of Provider Operations
- Director of Credentialing
- Senior Compliance Auditor
- VP of Audit and Monitoring

Overall Assessment

For Enrollee services, MCS had one open CAP item from CY 2022 pertaining to processes for providers to follow when a provider issues a moral and religious objection resulting in a refusal to provide, reimburse or not provide a referral or prior authorization based on an objection of this type. During the virtual on-site review, the MCS shared supporting documents and evidence which operationalized this standard across all provider-interfacing units within the organization. However, since these activities all occurred in 2024, the CAP will remain unchanged from CY 2023.

MCS demonstrated evidence of their amended provider guidelines, including an amendment letter distributed to all providers outlining the proposed changes and how these changes would be incorporated into the next cycle of the published provider guidelines. The letter also outlined CFR requirements and contract timeline expectations which included notification to ASES within 120 days before adopting the policy, notification to the member within 90 days after adopting the policy, and notification processes for members and potential Enrollees before and during enrollment.

The MAO amended their credentialing process and incorporated this regulation into the credentialing questionnaire to include any moral or religious objections providers may have. If a provider has any moral or religious objections, the information is added to their claims system which specifies the service limitation. MCS also provided a training schedule and communications plan for all MAO service areas which shows that all service areas have all been notified and trained on any new processes related to this regulation.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Enrollee Rights and Protections	1	0	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place to ensure: (5.5.1-5.5.3) If, during the course of the contract period, pursuant to 42 CFR 438.102, the contractor elects not to provide, not to reimburse for, or not to provide a Referral or Prior Authorization for a service within the scope of the detailed Covered Services, because of an objection on moral or religious grounds, the contractor shall notify ASES within 120 calendar days before adopting the policy with respect to any service; Enrollees within 90 calendar days after adopting the policy with respect to any service; and Enrollees before and during Enrollment. The contractor shall furnish information about the services it does not cover based on a moral or religious objection to ASES.	Not Met	Not Met	During the virtual on-site review, MCS shared supporting documents and evidence which operationalized this standard across all provider-interfacing units within the organization in 2024. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Continue all planned and active CAP activities in 2024 to reach compliance for this CAP item, including but not limited to submission of applicable P&Ps, evidence of notification to providers of the policy change, revised provider guidelines, and evidence that staff have been trained on all changes. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy (including the analysis) will require completion during CY 2024 for submission.

Provider Network

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MAO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MAO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MAO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MAO has written P&Ps for the selection and retention of providers and a documented process for the initial and re-credentialing of providers. Regulation 438.214 (c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214 (d) prohibits the MAO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with state requirements. The MAO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MAO has P&Ps in place which guarantee the MAO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MAO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MAO obtains state approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 4, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Leader, Customer Service
- VP, Network Operations
- Director, Credentialing
- Senior Compliance Auditor
- Representative, Audit and Monitoring

Overall Assessment

To meet the requirements for the CAP review, MCS submitted documentation such as P&Ps, trainings, and the annual network development and management plan, as well as targeted responses to the outstanding finding from the CY 2022 comprehensive review.

Reviewing the network from last year, MCS reported that less than 3% of their providers withdrew. MCS shared that there are no specific challenges identified for the provider network. MCS reports compliance with CMS health service delivery (HSD) required reporting and performs geo-access reporting every six months.

There was one topic area where follow up information was requested to meet the standards from the CY 2022 comprehensive EQR. MCS had submitted several policies that speak to the requirement of services being provided in a culturally competent manner but did not submit a comprehensive written Cultural Competency Plan. The CAP process included a request for the Cultural Competency Plan to be developed. MCS has contracted with a consulting firm to develop a Cultural Competency Plan. MCS targeted completion date is June 30, 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Provider Network	1	0	1

The following subcontractors support Provider Network functions:

Delegated Entity	Type of Entity and Services
Elixir	Pharmacy Benefit Services.

Delegated Entity	Type of Entity and Services
Eye Management of Puerto Rico, LLC	Vision Services – contracting, credentialing, and re-credentialing of optometry providers, providers call center and vision claims processing.
FHC Health System of Puerto Rico	MH Provider Services – contracting, credentialing, and re-credentialing of MH providers, provider and Enrollees' call centers, pre-service organization determinations, and appeals.
Therapy Network of Puerto Rico (TNPR) – also known as HN1 (Health Network One)	Physical, Occupational and Speech Services– provider contracting, and credentialing and re-credentialing of providers, providers' call center, pre-service organization determinations and claims processing.

The table below outlines an overview of the MAO network.

Provider Type	Number of Providers in CY 2023
Primary Care Physician (PCP) (total)	2,918
Adult	2,910
Pediatric	8
Primary Medical Groups (PMG)	21
Obstetrics and Gynecology (OB/GYN) Providers	432
Hospital	53
FQHC	17
Urgent Care	86
Nursing Facility	3
Adult and Pediatric Dental Providers	1,189
Vision	594
Adult High Volume Specialty Care Providers (total)	1,000
Cardiology	363
Endocrinology	144
Oncology	174

Provider Type	Number of Providers in CY 2023
Nephrology	164
Pulmonology	155
Pediatric High Volume Specialty Care Providers (total)	65
Cardiology	7
Endocrinology	4
Oncology	7
Pulmonology	5
Speech, Language and Hearing	42
Psychiatric Hospitals	15
Psychiatric Partial Hospitals	49
Adult and Pediatric Mental Health Providers (Psychologist, Psychiatrist, Licensed Clinical Social Worker and/or Licensed Professional Counselor)	2,111
SUD Inpatient Detoxification and/or Rehabilitation	0
SUD Intensive Outpatient (IOP) and/or Partial Hospitalization Provider (PHP)	0
Addiction Medicine/Withdrawal Management Provider	0

In addition, MCS Provided the following:

Provider Type	Number of Providers in CY 2023
Physical Medicine and Rehabilitation	149
Physical Therapy	170
Occupational Therapy	22
Speech Language Pathology	41

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
MAOs have P&Ps in place to (7.2.1.29) Require that the provider comply with the contractor's Cultural Competency Plan; (4.5.1) (42 CFR 438.206), have a comprehensive written Cultural Competency Plan describing how the contractor will ensure that services are provided in a culturally competent manner to all Enrollees.	Partially Met	Partially Met	CAP request was for the comprehensive written Cultural Competency Plan to be developed and submitted. MCS did not submit a plan, however, through the virtual on-site meeting, MCS shared that they have contracted with a consulting firm to develop a Cultural Competency Plan. MCS targeted completion date is June 30, 2024. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Develop a comprehensive written Cultural Competency Plan. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Care Management

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MAO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize quality of care and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Care Management	0	0	0

Findings

The MAO did not have CAP items in this area from the CY 2022 EQRO review.

Utilization Management (UM)

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MAO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MAO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MAO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 4, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- AVP of Clinical Administration
- Director of UM
- AVP of Auditing and Monitoring
- Senior Compliance Auditor

Overall Assessment

To address the requirements for the UM CAP review, MCS submitted documentation such as policies and targeted and narrative responses to the outstanding findings from the CY 2022 comprehensive review.

There were two topic areas where follow-up information was requested to meet the standards. Within the desk review submission, MCS responded to each item, however the items remain partially met, as MCS has reported a plan but the final documents providing evidence of the planned changes occurred outside of the required timeframe of CY 2023.

The following two CAP items required further action and had been scored as partially met from the CY 2022 comprehensive review.

- MCS does not have a formal documented process to ensure compliance with prior authorization requirements for parity in MH and SUD benefits.
- MCS did not provide written documentation prohibiting the MAO or any delegated UM agent from incentivizing UM decisions as per contractual and CFR requirements.
- MCS submitted the following documents to address the CAP:
- Policy UM03.C CA-UM-004 – Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitations (NQTL) Policy and Procedure Revised 03/28/2024.
- CA-PC-001 – Standard and Expedited PreService Organization Determinations – Favorable and Adverse Revised 01/29/2024 – CA-PC-002 – Standard and Expedited Dental Service Organization Determination Revised 01/29/2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Utilization Management	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has written P&Ps that: (i) identify, define, and specify the amount, duration, and scope of covered services available under the Contract and how and where to access such services; (42 CFR § 438.10. Platino section 4.3.1.2) The MAO has P&Ps to ensure its prior authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits under 42 CFR§	Partially Met	Partially Met	The CAP request was to develop a P&P that outlined the MAO process to ensure authorization requirements to comply with parity requirements. MCS developed the Policy UM03.C CA-UM-004 – Mental Health Parity and Addiction Equity Act (MHPAEA) Non-Quantitative Treatment Limitations (NQTL) Policy and Procedure which	Continue to develop parity dashboard and plan for use of assessment tool to conduct analysis. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy (including the analysis) will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
438.910(d) (Platino 5.3.9.2)			was revised 03/28/2024. This policy indicates MCS complies with all federal requirements contained in the MHPAEA. MCS reports the development of a comparative dashboard to monitor authorization data but currently is unable to provide a definite timeline on completion of the dashboard. MCS has also developed an assessment tool to monitor compliance. Staff have been informed of the revised policy through an established process. CAP remains unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has written P&Ps that prohibit the MAO or any delegated UM agent from providing compensation or anything of value to its employees, agents, or contractors based on: either a percentage of the amount by which a claim is reduced for the payment or the number of claims or the cost of services for the denied authorization or payment; or any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary covered service to any Enrollee. (Platino 8.2.4) (42 CFR § 438.210(e))	Partially Met	Partially Met	The CAP request was for a policy that included language prohibiting the MAO or delegated entity from incentivizing UM decisions. MCS submitted a revision of policies: CA-PC-001 – Standard and Expedited PreService Organization Determinations – Favorable and Adverse Revised 01/29/2024; CA-PC-002 – Standard and Expedited Dental Service Organization Determination Revised 01/29/2024. MCS has included this revision in the new hire training and staff will sign an attestation. CAP remains unchanged in 2023 findings since CAP activities are ongoing in 2024.	Continue to ensure staff are trained in the requirements and the policy is being followed. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the evidence of training, implementation and monitoring of the policy will require completion during CY 2024 for submission.

Grievance and Appeals (G&A)

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MAO must inform members of how to access the grievance system, the availability of the MAO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MAO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MAO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MAO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MAO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MAO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MAO must keep a log of all G&As filed. The MAO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate MCS's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MCS' CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 4, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Director of G&A
- Manager of G&A
- Supervisor of G&A
- AVP of Clinical Operation
- AVP of Provider Operations
- Director of Compliance Auditing and Monitoring
- Manager of Credentialing
- SVP of Clinical Programs
- Senior Compliance Auditor

Overall Assessment

The CY 2022 EQR identified two findings within the G&A requirements for MCS. The 42 CFR part 422 Subpart M and 42 CFR Part 438, Subpart F require the MAO to have a written grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System also must include a Complaint, Grievance, Appeal, and to the Administrative Law Hearing processes. While MCS staff articulated a process that incorporates Enrollee complaints as an integrated component of the G&A system, the written policy did not support contract requirements. Also, MCS P&Ps did not align with the Platino contract requirement regarding the continuation of benefits while the appeal and Administrative Law Hearings are pending. A CAP was developed and implemented to address these findings.

In response to the CAP, MCS has revised P&Ps in CY 2024 by incorporating the Platino contract requirements in article 11 to include the complaint process in its G&A system. MCS uses Beacon Healthcare System (Beacon) to register, track, and trend complaints and grievances. Also, Beacon has the capability to identify and report on Medicaid-only services. Monthly reports are generated and shared with both Compliance and Quality Departments for review and action. In addition, MCS has educated their staff following the P&Ps revision.

MCS also revised P&Ps in CY 2023 to align with the Platino contract regarding continuation of benefits while the appeal and ALH are pending, and MCS has submitted evidence of staff training following P&Ps revision. Continuation of benefits information has been incorporated into the Evidence of Coverage (EOC), member appeals decision letter, and provider manual to inform member and providers. In addition, MCS has posted EOC to its website. Although MCS has posted continuation of benefits information on its website via EOC, there is an

opportunity for MCS to provide additional information on the Grievance and Appeals section of the website to allow easier access to this information for Enrollees.

Out of two CAP items identified, one item is closed, and one item remains open as outstanding in the CY 2023 findings since CAP activities occurred in CY 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Grievance and Appeals	2	1	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has a written grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System includes a Complaint process, Grievance process, Appeal process, and access to the Administrative Law Hearing process. (42 CFR part 422 Subpart M) (42 CFR Part 438, Subpart F) (Platino 11.1; 11.1.2)	Partially Met	Partially Met	MCS provided revised P&Ps with the revision date of May 24, 2024. MCS uses Beacon Healthcare System (Beacon) to register, track, and trend complaints and grievances. Also, Beacon has the capability to identify and report on Medicaid-only services. Monthly reports are generated and shared with both Compliance and Quality Departments for review and action. In addition, MCS has educated their staff following the P&Ps revision. CAP will remain unchanged in CY 2023 findings since CAP activities occurred in 2024.	Develop P&Ps to support contract requirements outlined in article 11 including appropriate definitions for and tracking and trending of complaint, grievance, and appeals data. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO's P&Ps ensure continuation of benefits while the MAO appeal and Administrative Law Hearing are pending. (42 CFR § 438.420) (Platino 11.7)	Partially Met	Met	All documentation is present and completed in CY 2023. MCS staff responses are consistent with each other and the supporting documentation, and MCS provided evidence of compliance.	N/A

Quality Improvement and Assessment

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, G&A, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330 (b–e).

The intent of this regulation is to ensure the MAO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Findings

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Quality Improvement and Assessment	0	0	0

MCS did not have CAP items in this area from the CY 2022 EQRO review.

MMM Platino

Administration and Organization

Organizational Structure

MMM administers its Platino plan under MMM Healthcare, LLC., a subsidiary of MMM Holdings, LLC. MMM Holdings offers a GHP and Platino line of business in Puerto Rico. MMM serves approximately 291,000 members under their Platino Plan.

MMM's headquarters are located in Puerto Rico. The MAO operates 13 regional centers located in Carolina, San Juan, Bayamón, Manatí, Hatillo, Aguadilla, Mayaguez, Ponce, Guayama, Caguas, Canóvanas, Fajardo, and Humacao which operate during regular business hours of Monday to Friday, 8:00 am to 5:00 pm. The service centers work directly with beneficiaries to address needs such as ID card requests, benefits orientations, coverage certification, eligibility status, PCP changes, coverage changes, demographic changes, appointment coordination, G&A, Coordination of Benefits (COB) information, and material requests.

Since the last review, MMM has undergone some key leadership changes. The CFO retired in December 2023 and his position has been filled. The Chief Marketing and Communications Officer has also left the company and was replaced in March 2024. There have been no organizational changes since the last review. MMM Platino operates under a corporate board of directors which oversees an executive leadership team. This executive leadership team is the same for all LOBs under MMM Holdings, LLC., and includes a Compliance Officer, the COO, the CMO, the Quality Management/Five Star Operations VP, and legal counsel. Quality Management and Clinical Services are overseen by the Quality Management/Five Star Operations VP, the COO oversees Enrollee Services, and the CMO oversees UM and G&A. All employees of MMM Healthcare, LLC. are dedicated to work in Puerto Rico. Organization-wide, MMM employs a total of over 3,000 employees that support their health plans, of which 1,210 are fully dedicated to their Platino plan.

Delegated Entities

In 2023, MMM Platino delegated responsibilities to five entities described in the table below. Three of these entities, CVS, Insight, and MC-Rx, were terminated in 2023. None of these contracts were terminated due to performance-related concerns. CVS and MC-Rx were replaced by Abarca as the pharmacy benefit manager (PBM) in 2024.

Delegated Entity	Type of Entity and Services
ATENTO	Beneficiary call center
Abarca (PBM)	Pharmacy benefit management
Management Service Organization (MSO) of Puerto Rico	UM, Clinical Services (physical and MH), Claims, Pharmacy, HRA, Contracting, Credentialing, and Network Management. Audits and monitors contracted delegated entities.

Under the MSO of Puerto Rico, a related entity to MMM Healthcare LLC., the following entities are sub-delegated. Turning Point's contract was terminated in September 2023. Turning Point provided UM oversight of cardiovascular and musculoskeletal benefits which no longer required prior authorizations, and as such, their contract was terminated.

Delegated Entity	Type of Entity and Services
Eye Management of Puerto Rico (EMPR)	Vision Services — contracting, credentialing, and re-credentialing of optometry providers, providers call center, and vision claims processing.
InHealth Management	Hospital UM.
INSPIRA	MH Services — contracting and credentialing of MH providers.
Net Claims Solution	Dental Services— claims processing, direct members reimbursements, dental preservice platform.
Telemedik	Call Center Operations (triage, transportation, preauthorizations, outbound calls, other – Discharge Planning Program, smoking cessation, and HRA support.)
Therapy Network of Puerto Rico (TNPR) – also known as HN1 (Health Network One)	Physical, Occupational, and Speech Therapy — contracting, credentialing, and re-credentialing of providers, providers call center, pre-service organization determinations, and claims processing.

MMM Platino has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities and provided evidence of similar policies utilized by MSO of Puerto Rico for sub-delegates. MMM Platino and MSO of Puerto Rico have dedicated Delegation Oversight Units, which are responsible for contract and regulatory oversight of their delegated entities. The Delegation Oversight Unit under MMM Platino falls under the Compliance Department within MMM Healthcare's organizational structure. Under the MSO

of Puerto Rico, the unit reports directly to the MSO's Provider Internal Operations department.

Accreditation

Although not a contractual requirement, MMM Platino has an NCQA accreditation for the NCQA Population Health Program, with the most recent review in July 2022. Re-accreditation is due in April 2025 and the plan is seeking a new accreditation for Health Equity (expected effective date in July 2024). MMM also reports that several delegates hold accreditations: TNPR has an active NCQA UM and Credentialing accreditation (most recent review in April 2023) and Telemedik has a URAC accreditation (most recent review in August 2023). A former delegate, MC-21, had a URAC accreditation during the CY 2023 review period (most recent review in January 2022).

Employee Training

MMM has an established training program for new hires, subcontractors and providers offered virtually or via an online educational platform. MMM requires new hire training within 90 days of hiring and requires either an exam or an attestation of completion. All subcontractors must present attestations as proof of completion. Staff and all delegates and sub-contractors are trained in advance directives, cultural competency, FWA, HIPAA, BH, Enrollee rights, G&A, and Medicaid and covered Medicaid services.

Enrollee Rights and Protections

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MAO complies with the state enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MAO has written policies related to Enrollee rights and ensure the MAO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable state and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MAO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MAO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MAO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MAO maintains P&Ps related to advance directives, including their rights under state law, and must contain clear and concise language on the limitation if the MAO cannot implement an advance directive as a matter of conscience. The MAO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the state laws. The MAO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate MMM Platino's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM Platino's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 5, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Compliance Director
- Compliance Manager
- Operations Director
- Membership Director
- Enrollment Manager
- Clinical Information Director

Overall Assessment

For Enrollee Services, MMM Platino had one CAP item identified in 2022 pertaining to the process for providers to follow when they issue a moral or religious objection resulting in a refusal to provide, reimburse or not provide a referral or prior authorization based on an objection of this type. To move towards compliance with this CAP item, MMM developed an updated P&P (HSD-41-Moral and Religious Objections Policy dated 02/14/2024) which outlines procedures contractors must follow if they issue a moral or religious objection. The policy states that contractors must notify ASES within 120 calendar days of these decisions and members will be notified within 90 calendar days after adopting the policy respective to the service. Enrollees will also be notified before and during enrollment. Further, the policy indicates that employees will be trained on the notification processes pertaining to moral and religious objections. The most recent training occurred on February 15, 2024, the P&P was formally incorporated into the corporate P&Ps and distributed to employees on March 29, 2024, and the provider manual was updated accordingly on March 8, 2024. However, since all activities pertaining to the CAP occurred in the 2024 the CAP will remain unchanged for 2023.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Enrollee Rights and Protections	1	0	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place to ensure: (5.5.1-5.5.3) If, during the course of the Contract period, pursuant to 42 CFR 438.102, the contractor elects not to provide, not to reimburse for, or not to provide a referral or prior authorization for a service within the scope of the detailed Covered Services, because of an objection on moral or religious grounds, the contractor shall notify ASES within 120 calendar days before adopting the policy with respect to any service; Enrollees within 90 calendar days after adopting the policy with respect to any service; and Enrollees before and during Enrollment. The contractor shall furnish information about the services it does not cover based on a moral or religious objection to ASES.	Not Met	Not Met	MMM developed an updated P&P (HSD-41-Moral and Religious Objections Policy dated 02/14/24) which outlines procedures contractors must follow if they issue a moral or religious objection. The CAP will remain unchanged for 2023 since all CAP activities occurred in 2024.	Continue all planned and active CAP activities in 2024 to reach compliance for this CAP item. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Provider Network

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MAO participates in the State's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MAO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MAO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MAO has written P&Ps for the selection and retention of providers and a documented process for the initial and recredentialing of providers. Regulation 438.214 (c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214 (d) prohibits the MAO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with state requirements. The MAO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MAO has P&Ps in place which guarantee the MAO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MAO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MAO obtains state approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To meet the requirements for the CAP review, MMM submitted documentation such as P&Ps, trainings, and the annual Network Development and Management Plan as well as targeted responses to the outstanding finding from the CY 2023 comprehensive review. To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM Platino's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 5, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Director of Provider Network
- Manager of Contracting Operations
- Staff VP of Network Management
- Senior Director of Service Operations
- Supervisor
- Director of Network Management
- Manager of Compliance
- Director II of Compliance

Overall Assessment

MMM reported that there are no significant changes in the provider network since the CY 2023 comprehensive EQR. In addition, there are no obstacles for contracting and credentialing for both Medicaid and Medicare.

There were two topic areas where follow up information was requested to meet the standards. Within the desk review submission, MMM responded to each item by updating relevant policies and procedures for report development to track and monitor tasks related to provider termination and required turnaround times. The updated P&Ps include the process for internal communication with the compliance department to notify and communicate with ASES. The metrics remain partially met, as the updated P&Ps were put into place in 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Provider Network	2	0	2

Since the CY 2023 comprehensive EQR, MMM has changed from contracting with MC-Rx (former MC-21 Inc.) to Abarca as the Pharmacy Benefit Management Services.

MMM Delegated Entity	Type of Entity and Services
MSO of Puerto Rico	Provider contracting and credentialing, network adequacy. MSO may also subcontract to other entities.
Abarca	Pharmacy Benefit Management Services, including contracting and management of the pharmacy network.

The following subcontractors for MSO support Provider Network functions.

MSO Delegated Entity	Type of Entity and Services
Inspira Behavioral Care Corporation	Network functions, including credentialing.
Therapy Network of Puerto Rico	Physical, Occupational, and Speech provider contracting and credentialing.
Eye Management of Puerto Rico (EMPR)	Contracting, credentialing, and re-credentialing of optometry providers.

The table below outlines an overview of the MAO network.

Provider Type	Number of Providers in CY 2023
Primary Care Physician (PCP) (total)	Not Reported
Adult	2,420
Pediatric	2,407
Primary Medical Groups (PMG)	25
Obstetrics and Gynecology (OB/GYN) Providers	406
Hospital	48
FQHC	n/a
Urgent Care	86
Nursing Facility	6
Adult and Pediatric Dental Providers	1,107
Vision	1,215

Provider Type	Number of Providers in CY 2023
Adult High Volume Specialty Care Providers (total)	Not reported
Cardiology	391
Endocrinology	153
Oncology	248
Nephrology	206
Pulmonology	187
Pediatric High Volume Specialty Care Providers (total)	Not reported
Cardiology	3
Endocrinology	1
Oncology	3
Pulmonology	0
Speech, Language, and Hearing	107
Psychiatric Hospitals	9
Psychiatric Partial Hospitals	28
Adult and Pediatric Mental Health Providers (Psychologist, Psychiatrist, Licensed Clinical Social Worker and/or Licensed Professional Counselor)	949
SUD Inpatient Detoxification and/or Rehabilitation	n/a
SUD Intensive Outpatient (IOP) and/or Partial Hospitalization Provider (PHP)	n/a
Addiction Medicine/Withdrawal Management Provider	n/a

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place to report to ASES (10.5.9) at least two business days prior to taking any action against a provider for program integrity reasons, including, but not limited to, denial of a Provider Credentialing/Re-Credentialing application, corrective action or limiting the ability of a provider to participate in the program (e.g., suspending or terminating a provider) and 7.3.1 The contractor shall comply with all Puerto Rico and federal laws regarding provider termination.	Partially Met	Partially Met	The Provider Termination policy was updated on February 14, 2024, to include generating the report that will be used to monitor timeframes related to provider termination, timeframes for notifying ASES and generating the required report. The "Procedure – Reporting Requirements" was updated on April 1, 2024, to include all reporting requirements by ASES for Platino Enrollees, and the included policy also depicts the process. The Reporting Requirements Procedure will be presented for approval at the next Compliance Committee meeting, which is scheduled for June 26, 2024. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has reporting P&Ps in place to ensure accuracy and completeness of provider credentialing, and reports are sent to ASES including termination reports: (7.3.2-7.3.3) The contractor shall notify ASES at least 45 calendar days prior to the effective date of the suspension, termination, or withdrawal of a provider from participation in the contractor's network. If the termination was "for cause," the contractor shall provide to ASES the reasons for termination immediately. Within 15 calendar days after receipt or issuance of a notice of termination to a provider, provide written notice of the termination to Enrollees who received his or her Primary Care from, or was seen on a regular basis by, the terminated provider, and shall assist the Enrollee as needed in finding a new provider.	Partially Met	Partially Met	MMM provided an updated provider termination policy and an updated FWA policy which includes the process to generate the report needed and the process to notify ASES 45 days prior to termination of a provider. The updated report will track the termination process with timing requirements and will be used to communicate with compliance (who will notify ASES) and for monitoring. The FWA policy will be presented for approval at the next Compliance Committee meeting, which is scheduled for June 26, 2024. The update to the Provider Termination policy was made on February 14, 2024, and the update to the FWA policy was made on April 1, 2024. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Care Management

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MAO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize Quality of Care (QOC) and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Care Management	0	0	0

Findings

MMM Platino did not have CAP items in this area from the CY 2022 EQRO review.

Utilization Management

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MAO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MAO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MAO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM Platino's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 5, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- VP of Health Services (InHealth)
- Director of BH Program Services
- Director of Healthcare Management
- Clinical Director of Pharmacy Operations
- Director of Pharmacy Oversight
- Director of UM
- Director of Compliance

Overall Assessment

To address the requirements for the UM CAP, MMM submitted documentation such as policies and targeted narrative responses to the outstanding findings from the CY 2022 comprehensive review.

There were two topic areas where follow-up information was requested to meet the standards. Within the desk review submission, MMM responded to each item, however the topic areas remained partially met as MMM is still developing a process for one indicator and the other indicator was not implemented in the review year of 2023.

The following two CAP items required further action and had been scored as “Partially Met” from the CY 2022 comprehensive review:

- Submit a policy that outlines MMM’s process to ensure authorization requirements comply with parity requirements.
- Revise UM policies to include language prohibiting MMM or any delegated UM agent from incentivizing UM decisions.
- MMM submitted the following documents to address the CAP:
  - RFI Response
  - HSIP-030: Deviation Notification, Adverse Determination and Appeals Process (10/31/23) Section 6.5.11
  - HSIP-031 Hospital Open Cases (02/27/2024) Section 6.10
  - HSIP-036 Hospital Readmission Process (02/27/2024) Section 6.7
  - Coverage of Service 2024 UM Program Section F, Financial Compensation Disclosure
  - BH-CC-10 Organizational Determinations (01/31/2024) Section 3.0

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Utilization Management	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has written P&Ps that: (i) identify, define, and specify the amount, duration, and scope of covered services available under the contract and how and where to access such services; (42 CFR § 438.10. Platino section 4.3.1.2) The MAO has P&Ps to ensure its prior authorization requirements comply with the requirements for parity in MH and substance use disorder benefits under 42 CFR § 438.910(d) (Platino 5.3.9.2)	Partially Met	Partially Met	MMM provided a draft policy: Health Equity and Mental Health Parity Policy. The policy is scheduled for approval at the Medical Policy meeting in June 2024. The policy includes language on training staff and conducting an annual analysis. Upon policy approval, MMM will determine timeframes to begin and complete the analysis. The Medical Policy team will lead the analysis with support from other departments. An annual review schedule will be established. MMM provided an analysis template example. Training on parity has been incorporated into the training schedule. CAP will remain unchanged in the CY 2023 findings since CAP activities occurred in 2024.	Continue to implement the parity analysis plan. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation and monitoring of the policy (including the analysis) will require completion during CY 2024 for submission.
The MAO has written P&Ps that prohibit the MAO or any delegated UM agent from providing	Partially Met	Partially Met	The MAO reported in 2023 that this is standard practice and provided the	Continue to ensure staff are trained in the requirement and

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
compensation or anything of value to its employees, Agents, or contractors based on: either a percentage of the amount by which a claim is reduced for the payment or the number of claims, or the cost of services for the denied authorization or payment; or any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary covered service to any Enrollee. (Platino 8.2.4) (42 CFR § 438.210€)			program description which included acceptable language. The MAO updated three polices to include this language: **HSIP-030 UM-03** Notification, Adverse Determination and Appeals Process Effective 10/31/2023 – Section 6.5.11 **HSIP-031 UM-03** Hospital Open Cases Effective 02/27/2024 Section 6.10 **HSIP-036 UM-03** Hospital Readmissions Process Effective 02/27/2024 Section 6.7 This information is included in the new hire orientation/ onboarding for all employees who work with MMM. Inpatient auditors are required to sign an attestation. CAP will remain unchanged in the CY 2023 findings since CAP activities occurred in 2024.	monitor that policy is being followed. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Grievance and Appeals

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MAO must inform members of how to access the grievance system, the availability of the MAO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MAO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MAO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MAO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MAO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MAO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MAO must keep a log of all G&A filed. The MAO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate MMM Platino's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of MMM Platino's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 5, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Director of G&A
- Manager of G&A
- Director of Compliance
- Manager of Compliance

Overall Assessment

The CY 2022 EQR identified six findings that required CAP within the G&A requirements for MMM Platino. 42 CFR part 422 Subpart M and 42 CFR Part 438, Subpart F require the MAO to have a written grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System also must include a Complaint process, Grievance process, Appeal process, and access to the Administrative Law Hearing process. Findings from the CY 2022 review include managing Enrollee complaints by Enrollee Services department rather than as an integrated component of the G&A system, absence of P&Ps that include a process to ensure written Notices of Adverse Benefit Determination to Enrollees meet the language and format requirements and be set in accordance with the timeframes described in the Platino contract as well as for collecting and analyzing the G&A system data (including complaints data) for inclusion in the plan's quality strategy, absence of including language in the Provider Guidelines that clearly explain that an Enrollee, Enrollee's authorized representative, or provider (with Enrollee's written consent) may file a complaint, grievance, service authorization request, appeal, or request an administrative law review verbally or in writing with the MAO or with the Office of the Patient Advocate of Puerto Rico, that the MAO will acknowledge receipt of each grievance within 10 business days of receiving the grievance; and that Enrollee can file an appeal verbally without a written follow-up or the timelines to receive an acknowledgement of their appeal, and not having a process in place to notify ASES of appeal outcomes as required by Platino contract.

In response to these findings, MMM Platino developed and implemented a CAP in CY 2024. MMM revised P&Ps and Provider Manual by incorporating EQR recommendations to include an Enrollee's ability to file a complaint, grievance, appeal, and expediated appeal verbally or in writing, requirements and timeframes for filing, the Enrollee's right to file a complaint, grievance, or appeal with the Patient Advocate Office, the Enrollee's right to an Administrative Law Hearing, the availability of assistance in filing a complaint, grievance, service authorization requests or appeal, the toll-free numbers to file oral complaint, grievance, service authorization, and appeals, and the Enrollee's right to request continuation of benefits pending an Administrative Law Hearing. P&Ps revisions were followed by staff training on updated changes. Following the Provider Manual update, MMM Platino staff reported that the revised manual is uploaded to the provider portal without a

summary of changes. It is recommended that MMM Platino creates a summary of changes to the Provider Manual and share with providers to gain providers' attention to affected areas.

MMM Platino uses Onbase, a grievance and appeals system, to register, track, and trend complaints, grievances, and appeals, and the system has the capability to identify complaints, grievances, and appeals related to Medicaid-only services. Also, Onbase generates reports to track timeliness of resolution, evaluate patterns categories, and identify trends. This information is shared with other operational areas and vendors for appropriate action and with the Quality Improvement and Operations Committee.

MMM Platino utilizes a grievance acknowledgement letter previously approved by CMS and includes the Multi-Language Insert that approved by OMB (OMB# 0938-1421) with all Enrollee notices. The insert informs Enrollees that all written materials are available in alternative formats and the toll-free and TTY/TDD telephone numbers of the appropriate customer service line.

Finally, MMM Platino is currently in the process of working with ASES to gain access to their FTP server to send Written Notice of Disposition of an Appeal provided to Enrollees.

One out of six CAP items identified is closed, and five CAP items remain open as outstanding in the CY 2023 findings since CAP activities occurred in CY 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Grievance and Appeals	6	1	5

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has a written grievance system under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System includes a Complaint process, Grievance process, Appeal process, and access to the Administrative Law Hearing process. (42 CFR part 422 Subpart M) (42	Partially Met	Partially Met	MMM has revised policy, AG 003, Part C and D Standard Grievances, on February 22, 2024, by incorporating EQR recommendations. MMM uses Onbase, an appeals and grievance system, to register, track, and trend complaints,	Develop P&Ps to support contract requirements outlined in article 11 including appropriate definitions for and tracking and trending of complaint, grievance, and appeals data. To gain compliance for the next EQRO review cycle, (CY 2024, which will

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
CFR Part 438, Subpart F) Platino Article 11.1; 11.1.2.			grievances, and appeals, and the system has the capability to identify complaints, grievances, and appeals related to Medicaid-only services. Reviewed screenshots of Onbase to confirm its capability to categorize complaints, grievances, and appeals. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.
The MAO's Grievance System P&Ps include at a minimum: Process and timelines for filing a complaint, grievance, service authorization request or appeal, or seeking an Administrative Law Hearing; Process for receiving, recording, tracking, reviewing, reporting, and resolving grievances, service authorization requests and appeals filed verbally, in writing, or in-person; Process and timeframe for Enrollee's authorized representative or provider	Not Met	Met	MMM includes the Multi-Language Insert approved by OMB (OMB# 0938-1421) with all member notices. MMM also has P&Ps that comply with the Platino contract requirements pertaining to all written materials and taglines that explain the availability of written and oral translation to understand the information provided. All areas were completed in 2023.	N/A

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
to file a standard or expedited complaint, grievance service authorization or appeal on behalf of Enrollee; Process for notifying Enrollees of their right to file a complaint, grievance, or appeal with the Patient Advocate Office and how to contact the Patient Advocate Office; Procedures for the exchange of information with providers, ASES, and Enrollees regarding complaints, grievances, service authorizations and appeals; Process and timeframes for notifying Enrollees in writing regarding receipt, resolution, and other action related to, complaints, grievances, service authorizations and appeals. Including requirements governing the delay of reviews and extension requests as well as denial of request for expedited review. (Platino 11.1.5)			All requirements for this metric are met through RFI documents, on-site discussions, and post on-site submissions. This CAP item is closed.	
The MAO's policies, procedures, Enrollee Handbook, and Provider Manual clearly explain that an Enrollee, Enrollee's authorized representative, or provider (with Enrollee's written consent) may file a complaint, grievance, service authorization request, appeal, or request	Partially Met	Partially Met	MMM updated the 2024 Provider Manual in Section 4.1 to include all the required information regarding the G&A system as required in the Platino contract, Article 11.1.11.	Revise the Provider Guidelines to include all elements outlined in the Platino contract. It is recommended that MMM creates a summary of changes/update to the Provider Manual

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
an Administrative Law Review verbally or in writing with the MAO or with the Office of the Patient Advocate of Puerto Rico. (42 CFR §438.402(c)(3)) (Platino 11.1.5.3; 11.1.8; 11.1.11)			CAP will remain unchanged in the CY 2023 findings since CAP activities occurred in 2024.	and share with providers to gain provider's attention to affected areas. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.
The MAO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that a grievance may be filed at any time and that the MAO will acknowledge receipt of each grievance in writing within 10 business days of receiving the grievance. (Platino 11.3.1-3 and 11.5) (42 CFR §438.402.(2)(i))	Not Met	Not Met	MMM updated the 2024 Provider Manual in section 4.1 to include all the required information regarding the G&A system as required in the Platino contract, article 11.1.11. MMM utilizes a CMS approved acknowledgement letter. The letter contains a field to document the date received as well as the send date. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Revise Enrollee and provider materials to include information on how and when the Enrollee will receive an acknowledgement following receipt of a grievance. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO's P&Ps, Enrollee Handbook, and Provider Manual clearly state that an Enrollee may file an appeal verbally or in writing within 60 calendar days after receiving an Adverse Benefit Determination and will acknowledge receipt of the appeal. The contractor shall acknowledge receipt of each appeal in writing within 10 business days. (42 CFR §438.402 (2)(ii)) (Platino 11.5.4 and 11.5.6).	Not Met	Not Met	MMM has updated the 2024 Provider Manual to include that an Enrollee can file an appeal verbally or in writing. It also has updated P&Ps, AG-001, Section 3. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Revise the Provider Guidelines and P&Ps to include all elements outlined in the Platino contract. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.
The MAO's P&Ps clearly state time frames for standard resolution of appeals and notification of the decision within 30 calendar days. (42 CFR §438.408) Written notice of disposition of an appeal is provided to the Enrollee ASES within two business days of the decision. (11.5.10.1 and 11.5.13)	Partially Met	Partially Met	MMM is currently in the process of working with ASES to gain access to their FTP server to send written notice of disposition of an appeal provided to Enrollees. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Develop P&Ps to notify ASES of appeals outcomes within two business days of decision. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Quality Improvement and Assessment

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, G&A, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330 (b–e).

The intent of this regulation is to ensure the MAO has an ongoing quality assessment and PIP for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Findings

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Quality Improvement and Assessment	0	0	0

MMM Platino did not have CAP items in this area from the CY 2022 EQRO review.

Triple-S Platino

Administration and Organization

Process and Documentation Reviewed

Mercer conducted a desk review of submitted documentation as well as a virtual on-site meeting held June 6, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- VP of Performance Compensation
- Senior Compliance Auditor
- Director of Compliance and Monitoring
- Auditor of Compliance
- Director of Customer Service
- Supervisor of Customer Service

Organizational Structure

Triple-S Advantage (Triple-S Platino) is a subsidiary of Triple-S Management (TSM) Corporation which also includes Triple-S Salud (Medicaid), Triple-S Vida (life insurance), and Triple-S Propiedad (property and casualty insurance). In 2022, Guidewell Mutual Holding Corporation (GMHC) acquired TSM making it a wholly owned subsidiary of GMHC. TSM offers commercial, federal, Medicaid and Medicare Advantage LOBs in Puerto Rico. There are approximately 78,000 Medicare Advantage members. In the other LOBs, Medicaid is the largest with 468,843 members, followed by Commercial at 439,652 and Federal with 51,720. Triple-Salud and Triple-S Advantage are Blue Cross Blue Shield (BCBS) licensees and have the exclusive right to use the BCBS name and logo.

The Triple-S headquarters are located in San Juan, Puerto Rico. The MAO offers 16 service centers across the island which can directly assist members with various requests including printing ID cards and filing grievances. Most service centers are open Monday thru Friday from 8:00 am to 5:00 pm. There are two service centers that operate from 9:00 am to 6:00 pm and are also open on either Saturday or Sunday.

The Platino organizational structure falls under an Executive Affairs Administrator who reports directly to the CEO. This administrator oversees the President of Triple-S Platino, and numerous C-suite executives. The organizational structure of Triple-S Platino appears to share key positions with other Triple-S LOB.

The COO oversees UM (including preauthorization and facility-based care management), health management, contracting and administration, service administration (including call centers), innovation and integration, and provider relationships and partnerships. The Chief Strategy Officer manages contracting and administration, clinic networks, provider

relationships and partnerships, healthcare service and quality integration, and population health management. The CMO oversees medical quality, integrated delivery system, pharmacy, G&A, HEDIS and Stars, and the Quality Improvement Medical Director.

Triple-S employs approximately 2,350 staff and report that nine positions are solely dedicated to Plan Vital, 1,676 positions are shared across LOBs and 831 are dedicated to Medicare. Key departments include Enrollee Services, G&A, UM, Quality, Network/Provider Services, Coordination of Care, and Pharmacy.

Triple-S reports some changes in structure/positions. In November 2023, the following changes were implemented:

- A new role of VP of Operational Performance was created.
- The UM/Care Management and Health Management teams were combined under a single operation and will report to the SVP of Clinical Operations. A new hire began in this position on November 13, 2023.
- A new CFO was hired in September 2023 and the Network Strategic Function will fall under this position.

Delegated Entities

Triple-S Platino delegates responsibilities to nine different entities outlined in the table below. The Medical Advice Line was terminated since the last review and Pager and Beeper Medical Group is now responsible for those responsibilities.

Delegated Entity	Type of Entity and Services
Abarca (PBM)	Pharmacy benefit management
APS Healthcare of Puerto Rico	MH Services – MH benefits, MH provider network credentialing and re-credentialing, MH claims and processing and payment, pharmacy services, MH quality and UM services, behavioral health care management, MH and pharmacy G&A, MH education, reporting, MH Enrollee, and provider call center.
Clinical Medical Services	Durable Medical Equipment (DME) utilization management approvals.
LinkActiv	Call Center Services – for providers and beneficiaries and reporting.
Oncology Analytics (dba OncoHealth)	Oncology-related UM approvals.
Optum	Claims processing, IT.
Pager and Beeper Medical Group	Nursing advice line and medical advice line.

Delegated Entity	Type of Entity and Services
Telemedik	PSG call center Medicaid.
Therapy Network of Puerto Rico (TNPR) – also known as HN1 (Health Network One)	Physical, occupational, and speech language therapy UM approvals.

Triple-S Platino has P&Ps in place which operationalize the monitoring, oversight, and auditing of delegated entities. Oversight of delegated entities fall under the Triple-S Platino compliance and privacy officer, but other departments have a role in oversight as well:

- Contract Administrators are responsible for tracking and monitoring the delegated entity performance and day to day oversight for compliance issues.
- Subject Matter Experts evaluate reports produced and submitted by a delegated entity, reviews P&Ps related to their areas of expertise.
- The Compliance Department conducts audits and monitoring to test and confirm compliance and conducts Compliance to Compliance meetings on an at least quarterly basis.
- The Special Investigation Unit conducts the activities related to the prevention, detection, and referrals of potential FWA activities.
- The Vendor Management Oversight Committee reviews delegated entity performance as reported by Contract Administrators.

Accreditation

Plan Accreditation is not a contractual requirement. Triple-S Platino did not report any accreditations during this report period.

Employee Training

The MAO requires all newly hired employees to complete a training curriculum through a Learning Management System which includes topics such as a Review of the Triple-S Platino Compliance Program, Advance Directives, Cultural Competency, FWA, Elderly Financial Exploitation, Code of Business Conduct and Ethics, HIPAA, and a Medicaid Overview. Customer Service and G&A staff are required to also complete a training on grievances and appeals. Delegated entities must take trainings covering FWA, HIPAA, Code of Business Conduct and Ethics and a Medicaid overview. The UM delegated entities also participate in Inter-Rater Reliability (IRR) training. All staff must complete these trainings annually thereafter. Triple-S Platino utilizes a variety of formats to train employees, including online trainings, in-person class trainings and written educational materials.

Enrollee Rights and Protections

The following federal regulations are addressed in this section: 438.56.

The intent of these regulations is to ensure the MAO complies with the state enrollment and disenrollment requirements and limitations.

The following federal regulation is addressed in this section: 438.100 (d).

The intent of this regulation is to ensure the MAO has written policies related to Enrollee rights and ensure the MAO complies and holds staff and affiliated providers accountable to comply with Enrollee rights and applicable state and federal laws when providing services.

The following federal regulations are addressed in this section: 438.100 and 438.10.

The intent of these regulations is to ensure the MAO provides appropriate information to Enrollees and potential Enrollees in a language and format that is easily understood. The MAO must inform Enrollees of the availability of interpretive services and how to access those services. The process for ensuring specific Enrollee rights and protections is identified and communicated to members, staff, and providers acting on behalf of the MAO, including member's right to receive information from their providers freely and without restrictions.

The following federal regulations are addressed in this section: 438.100 (b) and 438.3 (j).

The intent of these regulations is to ensure the MAO maintains P&Ps related to advance directives, including their rights under State law, and must contain clear and concise language on the limitation if the MAO cannot implement an advance directive as a matter of conscience. The MAO is responsible for providing Enrollees with periodic written information regarding advance directives and their rights under the State laws. The MAO is expected to provide education for staff, providers, and the community regarding advance directives.

The following federal regulations are addressed in this section: 438.100 (b) and 438.102.

The intent of these regulations is to ensure the MAO informs Enrollees of their right to receive information and to receive that information in a timely manner. The MAO is responsible for ensuring Enrollees have the right to participate in decisions regarding their care, to be free from any form of restraint, and have the right to refuse treatment. Enrollees also have the right to receive information about available treatment options and alternatives. The MAO provides the Enrollee with information, including Enrollee rights, scope of benefits, changes to member benefits, provider terminations, and limitations of freedom of choice of providers.

Process and Documentation Reviewed

To evaluate the Triple-S Platino compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the MAO's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 6, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Compliance Auditor
- Enrollment Operations
- Reconciliation Regulatory Coordinator
- Compliance Manager
- Monitoring Director
- Regulatory and Contracting Advisor
- Customer Service Supervisor
- Customer Service Director

Overall Assessment

For Enrollee services, Triple-S Platino had one CAP item identified in CY 2022 pertaining to the process for providers to follow when they issue a moral or religious objection resulting in a refusal to provide, reimburse or not provide a referral or prior authorization based on an objection of this type. To move towards compliance with this CAP item, Triple-S updated the P&P "Written Agreement for Participating Providers" (TSS-NM-05) to reflect this contractual requirement (effective date 04/05/2024). Triple-S has trained all relevant internal departments about the policy change. Triple-S sent ASES the amended policy and provider guidelines. Once approval is received, Triple-S will formally notify the providers of policy change and distribute the provider guidelines. Since all activities pertaining to the CAP occurred in 2024 the CAP will remain unchanged for CY 2023.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Enrollee Rights and Protections	1	0	1

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place to ensure: (5.5.1-5.5.3) If, during the course of the contract period, pursuant to 42 CFR 438.102, the contractor elects not to provide, not to reimburse for, or not to provide a referral or prior authorization for a service within the scope of the detailed Covered Services, because of an objection on moral or religious grounds, the contractor shall notify ASES within 120 calendar days before adopting the policy with respect to any service; Enrollees within 90 calendar days after adopting the policy with respect to any service; and Enrollees before and during Enrollment. The contractor shall furnish information about the services it does not cover based on a moral or religious objection to ASES.	Not Met	Not Met	Triple-S has updated the P&P "Written Agreement for Participating Providers" (TSS-NM-05) to reflect the requirement pertaining to provider moral and religious objections (effective date 04/05/2024). Internal training has been completed. Provider notification of the policy change is on hold until the policy and provider guideline changes are approved by ASES. The CAP will remain unchanged since all CAP activities occurred in 2024.	Continue all active and planned CAP activities including but not limited to provider notification and training pertaining to the policy change. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Provider Network

The following federal regulation is addressed in this section: 438.206 (c) (2).

The intent of this regulation is to ensure the MAO participates in the state's efforts to deliver services in a culturally competent manner.

The following federal regulations are addressed in this section: 438.68, 438.206 (c) (1), and 438.207 (b–c).

The intent of these regulations is to ensure the MAO has an adequate network of appropriate providers to allow access to all covered services and that it takes into consideration the MAO's member demographics, needs, and geographic location when developing the network.

The following federal regulations are addressed in this section: 438.12 (a–b) and 438.214 (a–e).

The intent of these regulations is to ensure the MAO has written P&Ps for the selection and retention of providers and a documented process for the initial and re-credentialing of providers. Regulation 438.214 (c) and 438.12 (a–b) prohibits discrimination against providers that deliver services to high-risk or high-cost members. 438.214 (d) prohibits the MAO from contracting with providers that are excluded from participation in Medicare and state health care programs.

The following federal regulation is addressed in this section: 438.206 (b) (1–7).

The intent of this regulation is to ensure access to care is compliant with state requirements. The MAO is required to meet, and expects affiliated providers to meet, standards for access to care and services in-network or out-of-network (OON).

The following federal regulation is addressed in this section: 438.230 (a–b).

The intent of this regulation is to ensure the MAO has P&Ps in place which guarantee the MAO retains full accountability for any activities under the contract that are delegated to a subcontractor and that the MAO has processes in place to provide ongoing monitoring of contractors and the ability to take corrective action, if necessary.

The following federal regulation is addressed in this section: 438.104.

The intent of this regulation is to ensure the MAO obtains state approval for all marketing materials, distributes materials to its entire service area, does not seek to influence enrollment in conjunction with the offer of any private insurance, and does not engage in cold call marketing or other contractually restricted marketing techniques.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple-S Platino CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 6, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Regional Contracting Advisor
- Credentialing Director
- Compliance Audit and Monitoring Director
- Senior Compliance Partner
- Compliance Auditor

Overall Assessment

Triple-S reports that the network has been stable in the past few years. Additionally, there are no specific challenges or barriers to contract providers for both Medicaid and Medicare for dual eligible Enrollees.

There were two topic areas where follow up information was requested to meet the standards. Follow up documents requested were to address the following:

- The submitted contract by Triple-S during the 2023 comprehensive review stated that a second opinion is at the Enrollee's own expense with a contracted provider, however the metric states it should be at no cost, both in- and out-of-network. Triple-S was directed to update this information and provide the pathway to inform both Enrollees and providers. Triple-S updated the 'Out of Network and Emergency Services Providers Availability' policy to include language that "Triple-S shall provide a second opinion in any situation when there is a question concerning a diagnosis, the options for surgery, or alternative treatments of a health condition when requested by an Enrollee. The second opinion shall be provided by a qualified Network Provider, or, if a Network Provider is unavailable, Triple-S shall arrange for the Enrollee to obtain a second opinion from an Out-of-Network Provider. This second opinion shall be provided at no cost to the Enrollee." The policy approval date is March 26, 2024. Triple-S has a plan in place to distribute this information to members and providers, to develop internal workflow processes to ensure that the service department is clear on second opinion coverage and update the provider contracts including this language for second opinion coverage.
- During the 2023 comprehensive review, Triple-S shared multiple documents that included cultural competency, however there was not a specific Cultural Competency Plan as required by the Platino contract. Triple-S developed the Cultural Competency Plan in February 2024 and sent the document to the ASES. Once approved is received, Triple-S will notify providers via a circular letter and publish the plan on the provider portal.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Provider Network	2	0	2

The following subcontractors support Provider Network functions:

Delegated Entity	Type of Entity and Services
Abarca (PBM)	Pharmacy Benefit Management.
APS Healthcare of Puerto Rico	BH Services – network management activities, including contracting and credentialing.
LinkActiv	Call Center Services – for providers and beneficiaries and reporting.
Therapy Network of Puerto Rico (TNPR) – also known as HN1 (Health Network One)	Physical, Occupational and Speech Services – provider contracting and credentialing.

The table below outlines an overview of the MAO network.

Provider Type	Number of Providers in CY 2023
Primary Care Physician (PCP) (total)	2,559
Adult	2,559
Pediatric	Not reported
Primary Medical Groups (PMG)	10
Obstetrics and Gynecology (OB/GYN) Providers	534
Hospital	58
FQHC	49
Urgent Care	64
Nursing Facility	4
Adult and Pediatric Dental Providers	1,204
Vision (optical)	114

Provider Type	Number of Providers in CY 2023
Adult High Volume Specialty Care Providers (total)	1,353
Cardiology	516
Endocrinology	183
Oncology	183
Nephrology	263
Pulmonology	208
Pediatric High Volume Specialty Care Providers (total)	Not reported
Cardiology	Not reported
Endocrinology	Not reported
Oncology	Not reported
Pulmonology	Not reported
Speech, Language, and Hearing	42
Psychiatric Hospitals	10
Psychiatric Partial Hospitals	23
Adult and Pediatric Mental Health Providers (Psychologist, Psychiatrist, Licensed Clinical Social Worker and/or Licensed Professional Counselor)	1,389
SUD Inpatient Detoxification and/or Rehabilitation	9
SUD Intensive Outpatient (IOP) and/or Partial Hospitalization Provider (PHP)	9
Addiction Medicine/Withdrawal Management Provider	9

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps in place aligning with:(42 CFR § 438.206) (42 CFR 438.207(c)) (6.1.1- 6.1.2) establish and maintain a network of Network Providers that complies with 42 CFR 438.206(b)(l) and is otherwise sufficient to provide adequate access to covered services to meet the needs of Enrollees in the Medicare Platino Plan. This must include a women's health specialist to provide women's routine and preventive health care services, ability to obtain a second opinion, in or outside the network, at no cost to the Enrollee. Adequate and timely access and coverage for Network Providers as well as out-of-network services if contractor is unable to provide such access.	Partially Met	Partially Met	The policy, Out of Network and Emergency Services Providers Availability, includes language that “Triple- S shall provide a second opinion in any situation when there is a question concerning a diagnosis, the options for surgery, or alternative treatments of a health condition when requested by an Enrollee. The second opinion shall be provided by a qualified Network Provider, or, if a Network Provider is unavailable, Triple-S shall arrange for the Enrollee to obtain a second opinion from an Out-of-Network Provider. This second opinion shall be provided at no cost to the Enrollee.” The policy approval date is March 26, 2024. CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	The next steps described by Triple-S include distribution of information which will include internal workflow processes to ensure that the service department is clear on second opinion coverage. Triple-S is in the process of updating the provider contracts including this language for second opinion coverage. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
MAOs have P&Ps in place to (7.2.1.29) Require that the provider comply with the Contractor's Cultural Competency Plan; (4.5.1) (42 CFR 438.206), have a comprehensive written Cultural Competency Plan describing how the contractor will ensure that services are provided in a culturally competent manner to all Enrollees.	Partially Met	Partially Met	Triple-S Platino updated the Cultural Competency Plan in February 2024 to include required elements. The updated plan was sent to the ASES. Once approval is received, Triple-S will notify providers via a circular letter and publish the plan on the provider portal. CAP will remain unchanged in the 2023 findings since CAP activities are ongoing in 2024.	Once the Cultural Competency Plan is approved by ASES, Triple-S will notify providers via a circular letter and publish the plan on the provider portal. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Care Management

The following federal regulation is addressed in this section: 438.208 (b).

The intent of this regulation is to specify how care is provided in order to promote coordination and continuity of care to ensure the MAO has procedures to deliver primary care appropriate to a member's needs while maintaining privacy.

The following federal regulation is addressed in this section: 438.208 (c) (2–4).

The intent of this regulation is to address services provided to Enrollees with special health care needs, including processes that promote timely identification and assessment, to ensure services are provided in a manner that promotes coordination and continuity of care.

The contractor shall develop and implement an integrated Continuation of Care program that seeks to eliminate fragmentation in the care delivery system and promote education, communication, and access to health information for both members and providers to optimize QOC and member health outcomes.

The following federal regulations are addressed in this section: 438.224.

The intent of this regulation is to ensure that the MAO uses and discloses individually identifiable health information in accordance with the privacy requirements as applicable for medical records and any other health and enrollment information that identifies a particular Enrollee.

Process and Documentation Reviewed

To evaluate the MAO's compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of Triple-S's CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 6, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Health Management Program Director
- Medical Director
- Care Management Director
- Chief Compliance Officer
- Compliance Audit and Monitoring Director
- Senior Compliance Partner
- Compliance Auditor
- Privacy Analyst

Overall Assessment

The CY 2022 EQR identified two findings within in the Care Management requirements for Triple-S Platino. In §438.208 (c) (4) Coordination and continuity of care, States are expected to ensure that for Enrollees with special health care needs, the MCPs must have a mechanism in place that allows Enrollees to have direct access to a specialist as appropriate for the individual's condition and identified needs. During the CY 2022 EQR, Triple-S Platino staff had described the process for linking Enrollees with specialists, however, did not have a P&P in place to support the process. A CAP was developed and implemented to address this finding.

In response to the CAP, Triple-S Platino developed a Standard Operating Procedure (SOP), approved on March 19, 2024, entitled *Care Management Escalation Process* to *Link Members with Specialist or Sub-Specialist Out of Network or Non-Contracted* that describes the process of connecting Enrollees with specialists and sub-specialists that are either in-network or out-of-network (non-contracted). Two additional SOPs, *SOP-RID-2021-018 – Verificación de contratación del proveedor en QNXT* (Supplier Engagement Verification in QNXT), approved on March 19, 2024, and *SOP-UM-PA-004- Proceso de Manejo de Cartas de Acuerdo* (Letter of Agreement Handing Process), approved on October 23, 2023, were embedded in the SOP as an extension. When an Enrollee requests an in-network provider, Triple-S Platino follows the process outlined in *SOP-UM-PA-004.* The Triple-S Platino care management team validates the Enrollee coverage and collects required information from the specialist or sub-specialist and validates their network status. Upon verifying that the specialist or sub-specialist is in-network, a LOA is requested from the Provider Network Management, and the care management team makes an arrangement with the Enrollee. When an Enrollee requests an out-of-network provider, Triple-S Platino care manager contacts the Enrollee and provides education about seeing an in-network provider but will also refer the case to the Prior Authorization Department within two business days to enter the authorization when the Enrollee declines to see an in-network provider. The Prior Authorization Department sends the request to the Provider Network Management Department within two business days, to engage the provider and send a LOA with the expectation of seeing the Enrollee within seven to fourteen business days. Upon development of new SOPs, Triple-S Platino reported it has shared SOPs with impacted staff.

The second CY 2022 EQR finding resulted in a CAP to develop P&Ps describing oversight responsibilities with monitoring provider compliance with Care Management and Disease Management requirements. In response to the CAP, Triple-S Platino developed a SOP, *Oversight Responsibilities for Providers Compliance with Care Management Program*, in March 2024 that describes the Triple-S Platino's oversight process of provider adherence to requirements for monitoring Enrollees with a medical condition that could benefit from Care Management/Disease Management. The process includes identifying Enrollees by data stratification to include disease prevalence, comorbidity, cost, and utilization metrics. This information is distributed to medical group alliances and shared with primary care providers. Triple-S Platino works with each alliance for identifying candidates who could benefit from the care management and disease management programs and collaborates in contacting and referring members. Triple-S Platino's Providers Relationship and Partnership Department and the Providers Community Medical Director oversees the referral activities and shares data with the alliance and primary care providers via the quarterly Holistic Clinical Performance Meeting.

Both CAPs will remain unchanged in the 2023 findings since CAP activities occurred in 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Care Management	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has P&Ps for the identification of populations with special health care needs in order to identify any ongoing special conditions that require a treatment plan and regular care monitoring by appropriate providers. (Appendix C5), (6.1.2.7), (42 CFR § 438.208(c)(4)).	Partially Met	Partially Met	Triple-S Platino developed a Standard Operating Procedure (SOP) in CY 2024 that memorializes the process previously in place of connecting Enrollees with specialists and sub-specialists that are either in-network or out-of-network to ensure that Enrollees with special health care needs receive care. CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	Develop written P&Ps to formalize the approach to linking Enrollees to specialists or sub-specialists when a referral is indicated, including the escalation process and timeframe requirements. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO provider contracts include requirement for providers to monitor Enrollees to determine whether they have a medical condition that suggests Care Management or Disease Management services are warranted. (7.2.1.19)	Partially Met	Partially Met	Triple-S Platino developed a SOP in CY 2024 that describes its oversight responsibilities with monitoring provider compliance with Care Management and Disease Management requirements. New process includes sharing data with alliances known as Medical Groups, and Platino's Providers Relationship and Partnership Department and the Providers Community Medical Director monitors provider compliance by sharing referral data with providers at least quarterly via Holistic Clinical Performance Meeting. CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	Revise P&Ps to include development for oversight responsibilities with monitoring provider compliance with Care Management and Disease Management requirements. To gain compliance for the next EQRO review cycle, (CY 2024, which will be reviewed in 2025) the policy will need to be approved, and all training, implementation, monitoring, and oversight of the policy will require completion during CY 2024 for submission.

Utilization Management (UM)

The following federal regulation is addressed in this section: 438.236.

The intent of this regulation is to ensure the MAO, with input from providers, has clinical practice guidelines in place that reflect the needs of Enrollees and are based on valid and reliable clinical evidence.

The following federal regulation is addressed in this section: 438.210 (a–f).

The intent of this regulation is to ensure services offered to members are clearly identified and that the MAO has P&Ps for processing requests for services in a timely manner, ensuring the beneficiary appropriate access to services. This section also ensures the utilization review activities are constructed in a supportive manner for the Enrollee, and notification of intent to deny or limit services is communicated in a timely fashion.

The following federal regulations are addressed in this section: 438.10 (f–g) (viii–ix), 438.114, and 422.113 (c).

The intent of these regulations is to ensure the MAO assists the member to understand when and how to access emergency and post-stabilization services, including after hours.

Findings

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Utilization Management	0	0	0

Triple-S did not have CAP items in this area from the CY 2022 EQRO review.

Grievance and Appeals (G&A)

The following federal regulations are addressed in this section: 438.228.

The intent of these regulations is to ensure the MAO has in effect a grievance and appeal system that meets the requirements of 438.400.

The following federal regulations are addressed in this section: 438.402 and 438.406.

The intent of these regulations is to inform members of their rights under grievance, appeal, and State Fair Hearing processes. The MAO must inform members of how to access the grievance system, the availability of the MAO to assist in the process, and the timeliness for application and completion of each process step.

The following federal regulations are addressed in this section: 438.400 and 438.402.

The intent of these regulations is to ensure the MAO operates a grievance system that includes processes to adjudicate grievances, appeals, and State Fair Hearings, including the timelines and procedures for filing and that definitions used to define aspects of the grievance system are consistent with federal regulations.

The following federal regulations are addressed in this section: 438.10 (c–d), 438.404, 438.408, and 438.410.

The intent of these regulations is to ensure the MAO provides NOABD letters that are compliant with language, content, and format as required by Enrollee rights regulations. A process to ensure the grievance system operates within established time frames including requirements to adjudicate concerns under an expedited time frame.

The following federal regulation is addressed in this section: 438.406.

The intent of this regulation is to ensure the MAO provides Enrollees with assistance, if requested, to complete processes within the grievance system. The MAO has processes in place ensuring Enrollees have adequate time, information, and participation in the appeals review process. Only decision makers with appropriate knowledge and expertise participate in the grievance process.

The following federal regulations are addressed in this section: 438.414, 438.416, 438.420, and 438.424.

The intent of these regulations is to ensure the MAO provides information on the grievance system to providers and subcontractors at the time they enter into a contract. The MAO must keep a log of all G&As filed. The MAO must have a process to address continuation of benefits during the appeal process and reinstatement of services if an appeal is overturned.

Process and Documentation Reviewed

To evaluate the Triple-S Platino compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of the Triple-S Platino CAP items and supporting documentation. This review was conducted based on information submitted by the MAO through the RFI and through virtual on-site meetings held June 6, 2024. The virtual on-site meetings involved participation from MAO key leadership including, but not limited to:

- Director of Compliance Audit and Monitoring
- Manager of G&A
- Supervisor of G&A
- Analyst of G&A Quality
- Senior Compliance Auditor
- Compliance Auditor
- Compliance Auditor
- Customer Service Director
- Customer Service Supervisor
- Quality Improvement Medical Director

Overall Assessment

The CY 2022 EQR identified two standards that required corrective within the G&A requirements for Triple-S Platino. 42 CFR part 422 Subpart M and 42 CFR Part 438, Subpart F require the MAO to have a written Grievance System under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System also must include a Complaint process, Grievance process, Appeal process, and access to the Administrative Law Hearing process. Findings from the CY 2022 review revealed that Triple-S Platino manages Enrollee complaints in Enrollee Services department rather than as an integrated component of the G&A System. Also, Triple-S Platon's P&Ps stated that it may charge the Enrollee a reasonable cost for copying and mailing an appeal case file which directly contradicts 42 CFR §438.406 and Platino contract article 11.1.6.

In response to the first finding, Triple-S Platino submitted P&Ps, AG 008, Appeals and Grievances Data Categorization and Monitoring, revised on 05/28/2021 as part of the RFI. It should be noted that the same P&Ps were reviewed during the last review cycle. During the virtual on-site review, Triple-S Platino informed that it has revised P&Ps on February 6, 2024 with an approval date of March 8, 2024. However, Triple-S Platino continues to maintain a bifurcated process for complaints, grievances, and appeals. Regarding complaints, the Customer Service Department registers the case in *Follow It*, which is a customer relationship management software, and routs to appropriate operational areas for resolution as needed. While the Customer Service Department has the ability to generate reports to identify trends, this information is housed within the department. On the other hand, G&A

information is entered into a separate system, and data is reviewed the quality committee. Triple-S Platino should incorporate Complaint information as part of an integrated G&A System in accordance with Platino contract article 11.1.2 where it can use data to identify system improvement opportunities. Triple-S Platino delegates G&A functions to APS Healthcare for behavioral health services. During the virtual on-site review, Triple-S Platino staff stated APS Healthcare reviews its own G&A data quarterly in the Quality Committee.

For the second finding, Triple-S Platino submitted P&Ps, AG 003, Part C B Appeal with the RFI. Mercer was unable to review P&Ps as the document was encrypted. During the virtual on-site review, Triple-S Platino presented revised P&Ps with the revision date of February 8, 2024, and approval date of March 8, 2024. P&Ps revision incorporated an EQR recommendation to include that it provides the Enrollee or authorized representative with the Enrollee's case file, including medical records, other documents, and records free of charge and sufficiently in advance of the resolution timeframe for the Appeal.

Out of two CAP items identified, both will remain unchanged in the CY 2023 findings since CAP activities occurred in 2024.

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Grievance and Appeals (G&A)	2	0	2

Findings

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
The MAO has a written Grievance System under which Enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, Covered Services. The Grievance System includes a Complaint process, Grievance process, Appeal process, and access to the Administrative Law Hearing process. (42 CFR part 422 Subpart M) (42 CFR Part 438, Subpart F) Platino Article 11.1; 11.1.2.	Partially Met	Partially Met	Triple-S Platino provided revised P&Ps. P&Ps has the revision date of February 6, 2024, and approval date of March 8, 2024. Triple-S Platino continues to maintain a bifurcated process of tracking, trending, and analyzing complaints, grievances. and appeals. The Customer Service Department manages complaints while the G&A	Develop P&Ps to support contract requirements outlined in article 11 including appropriate definitions for and tracking and trending of complaint, grievance, and appeals data. Incorporate complaint information as part of an integrated G&A System in accordance with Platino contract article 11.1.2 where it can use data to

Regulation/Contract Standard Not Fully Compliant	2022 Review Score	2023 Review Score	Finding	Recommendation
			Department manages grievances and appeals. The Customer Service Department generates and review complaint data, while the G&A Department tracks, reviews, and reports G&A data to the Quality Committee for possible action. CAP will remain unchanged in the CY 2023 findings since CAP activities are ongoing in 2024.	identify system improvement opportunities. To gain compliance for 2024, submit the approved policy, notification evidence for providers, updated and revised provider guidelines, provide all training related to the implementation of the policy, oversight, and monitoring of implementation.
The MAO's G&A System fully complies with the Puerto Rico's Patient Bill of Rights Act, to the extent that such provisions do not conflict with or post an obstacle to federal regulations. The advisory board's advice to the MAO on resolution of Enrollee Grievances and Appeals. (42 CFR §438.406) (Platino 11.1.6)	Partially Met	Partially Met	Triple-S Platino provided revised P&Ps. P&Ps has the revision date of February 8, 2024, and approval date of March 8, 2024. The revised P&Ps state that it provides the Enrollee or Authorized Representative with the Enrollee’s case file, including medical record free of charge. CAP will remain unchanged in the 2023 findings since CAP activities occurred in 2024.	Update G&A P&Ps to align with the Platino contract. (11.5.2) To gain compliance for 2024, submit the approved policy, notification evidence for providers, updated and revised provider guidelines, provide all training related to the implementation of the policy, oversight, and monitoring of implementation.

Quality Improvement and Assessment

The following federal regulation is addressed in this section: 438.242.

The intent of this regulation is to ensure that the MAO maintains a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility.

The following federal regulation is addressed in this section: 438.330 (b–e).

The intent of this regulation is to ensure the MAO has an ongoing quality assessment and performance improvement plan (PIP) for the services it furnishes to its Enrollees. The assessment must include mechanisms to detect both under-utilization and over-utilization of services and mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Findings

Standard Reviewed by the EQRO	Number of CAP Items Identified in 2022	Number of CAP Items Closed in 2023	Number of Outstanding CAP Items in 2023
Quality Improvement and Assessment	0	0	0

Triple-S did not have CAP items in this area from the CY 2022 EQRO review.

Appendix C

MCO PM Reporting

Results of all Collected HEDIS Measures

Medicaid MCOs were required to report their HEDIS measure rates, numerators, and denominators for MY 2023. The following tables display the MCO specific reported HEDIS MY 2023 rates.

FMHP

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Effectiveness of Care: Prevention and Screening						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile						
3–11 Years	22,446	42	0.19%			
12–17 Years	13,887	43	0.31%			
Total	NR	NR	NR			
Counseling for Nutrition						
3–11 Years	22,446	486	2.17%			
12–17 Years	13,887	382	2.75%			
Total	NR	NR	NR			
Counseling for Physical Activity						
3–11 Years	22,446	95	0.42%			
12–17 Years	13,887	76	0.55%			
Total	NR	NR	NR			
Childhood Immunization Status (CIS)						
DTaP	3,252	140	4.31%			
IPV	3,252	380	11.69%			
MMR	3,252	1,238	38.07%			
HiB	3,252	634	19.50%			
Hepatitis B	3,252	75	2.31%			
VZV	3,252	1,206	37.08%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Pneumococcal Conjugate	3,252	141	4.34%			
Hepatitis A	3,252	1,580	48.59%			
Rotavirus	3,252	226	6.95%			
Influenza	3,252	126	3.87%			
Combination #2	NQ	NQ	NQ			
Combination #3	3,252	11	0.34%			
Combination #4	NQ	NQ	NQ			
Combination #5	NQ	NQ	NQ			
Combination #6	NQ	NQ	NQ			
Combination #7	3,252	6	0.18%			
Combination #8	NQ	NQ	NQ			
Combination #9	NQ	NQ	NQ			
Combination #10	3,252	1	0.03%			
Immunizations for Adolescents (IMA)						
Meningococcal	4,915	2,335	47.51%			
Tdap	4,915	2,335	47.51%			
HPV	4,915	927	18.86%			
Combination #1	4,915	2,269	46.16%			
Combination #2	4,915	892	18.15%			
Lead Screening in Children (LSC)	3,255	628	19.29%			
Breast Cancer Screening (BCS-E)						
18–64 Years	21,442	10,704	49.92%			
65+ Years	5,156	2,090	40.54%			
Total	NR	NR	NR			
Cervical Cancer Screening (CCS) 24-64 years	90,408	39,161	43.32%			
Chlamydia Screening in Women (CHL)						
16–20 Years	2,142	1,219	56.91%			
21–24 Years	3,355	1,892	56.39%			
Total	NR	NR	NR			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Colorectal Cancer Screening (COL)[10]						
46–49 Years	NR	NR	NR			
50–75 Years	NR	NR	NR			
Total	NR	NR	NR			
Effectiveness of Care: Respiratory Conditions						
Asthma Medication Ratio (AMR)[11]						
5–11 Years	NR	NR	NR			
12–18 Years	NR	NR	NR			
19–50 Years	NR	NR	NR			
51–64 Years	NR	NR	NR			
Total	NR	NR	NR			
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)				411	168	40.88%
Effectiveness of Care: Diabetes						
Hemoglobin A1c Control for Patients With Diabetes – HbA1c Control (<8.0%) (HBD)				411	83	20.19%
Blood Pressure Control for Patients With Diabetes (BPD)				411	129	31.39%
Eye Exam for Patients With Diabetes (EED)				411	74	18.00%
Kidney Health Evaluation for Patients With Diabetes (KED)						
18–64 Years	11,081	1,902	17.16%			
65–74 Years	1,839	282	15.33%			
75–85 Years	1,031	164	15.91%			
Total	13,951	2,348	16.83%			

[10] FMHP's final audit report listed COL data for 18-64 Years (denominator 58,033, numerator 20,004, and rate 34.47%) and 65+ (denominator 9,675, numerator 3,524, and rate 36.42%).

[11] FMHP's final audit report listed AMR data for 5-18 Years (denominator 111, numerator 107, and rate 96.40%) and 19-64 Years (denominator 499, numerator 469, and rate 93.99%).

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Effectiveness of Care: Behavioral Health						
Diagnosed Mental Health Disorders (DMH)						
1–17 Years	77,132	11,406	14.79%			
18–64 Years	198,221	21,742	10.97%			
65+ Years	16,587	1,796	10.83%			
Total	291,940	34,944	11.97%			
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment18–64 Years	210	5	2.38%			
Effective Acute Phase Treatment 65+ Years	20	2	10.00%			
Effective Continuation Phase Treatment 18–64 Years	210	0	0.00%			
Effective Continuation Phase Treatment 65+ Years	20	0	0.00%			
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	160	95	59.38%			
Continuation and Maintenance (C&M) Phase	0	0	0.00%			
Follow-Up After Hospitalization for Mental Illness (FUH)						
6–17 years — 30-Day Follow-Up	217	141	64.98%			
6–17 years — 7-Day Follow-Up	217	57	26.27%			
18–64 years — 30-Day Follow-Up	736	390	52.99%			
18–64 years — 7-Day Follow-Up	736	183	24.86%			
65+ years — 30-Day Follow-Up	34	14	41.18%			
65+ years — 7-Day Follow-Up	34	8	23.53%			
Total — 30-Day Follow-Up	NR	NR	NR			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Total — 7-Day Follow-Up	NR	NR	NR			
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
6–17 years — 30-Day Follow-Up	29	18	62.07%			
6–17 years — 7-Day Follow-Up	29	15	51.72%			
18–64 years — 30-Day Follow-Up	187	69	36.90%			
18–64 years — 7-Day Follow-Up	187	29	15.51%			
65+ years — 30-Day Follow-Up	13	3	23.08%			
65+ years — 7-Day Follow-Up	13	2	15.38%			
Total — 30-Day Follow-Up	NR	NR	NR			
Total — 7-Day Follow-Up	NR	NR	NR			
Diagnosed Substance Use Disorder (DSU)						
Alcohol (Total)	240,473	353	0.15%			
Opioid (Total)	240,473	867	0.36%			
Other (Total)	240,473	911	0.38%			
Any (Total)	240,473	1,827	0.76%			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
30-Day Follow-Up: 13–17 Years	8	1	12.50%			
7-Day Follow-Up: 13–17 Years	8	1	12.50%			
30-Day Follow-Up: 18–64 Years	226	24	10.62%			
7-Day Follow-Up: 18–64 Years	226	10	4.42%			
30-Day Follow-Up: 65 Years	14	2	14.29%			
7-Day Follow-Up: 65 Years	14	1	7.14%			
30-Day Follow-Up: Total	NR	NR	NR			
7-Day Follow-Up: Total	NR	NR	NR			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose 1–11 Years	237	124	52.32%			
Blood Glucose 12–17 Years	280	161	57.50%			
Blood Glucose Total 1–17 Years	517	285	55.13%			
Cholesterol 1–11 Years	237	94	39.66%			
Cholesterol 12–17 Years	280	136	48.57%			
Cholesterol Total 1–17	517	230	44.49%			
Blood Glucose & Cholesterol 1–11 Years	237	89	37.55%			
Blood Glucose & Cholesterol 12–17 Years	280	134	47.86%			
Blood Glucose & Cholesterol Total	517	223	43.13%			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	1,286	704	54.74%			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	809	37	4.57%			
Effectiveness of Care: Overuse/Appropriateness						
Appropriate Treatment for Children With URI (URI)						
3 Months–17 Years	8,096	0	0.00%			
18–64 Years	6,664	0	0.00%			
65+ Years	224	0	0.00%			
Total	14,984	0	0.00%			
Avoidance of Antibiotic Treatment in Adults with AcuteBronchitis (AAB)						
3 Months–17 Years	1,062	1	0.09%			
18–64 Years	558	0	0.00%			
65+ Years	51	0	0.00%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20–44 Years	116,769	58,217	49.86%			
45–64 Years	66,991	47,526	70.94%			
65+ Years	16,259	11,896	73.17%			
Total	200,019	117,639	58.81%			
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)						
Initiation – Alcohol 18–64 Years	270	193	71.48%			
Initiation – Alcohol 65+ Years	28	19	67.86%			
Initiation – Opioid Abuse or Dependence 18–64 Years	499	472	94.59%			
Initiation – Opioid Abuse or Dependence 65+ Years	7	7	100.00%			
Initiation – Other Drugs 18–64 Years	572	482	84.27%			
Initiation – Other Drugs 65+ Years	14	13	92.86%			
Initiation – Total 18–64 Years	1,321	1,127	85.31%			
Initiation – Total 65+ Years	49	39	79.59%			
Engagement – Alcohol 18–64 Years	270	17	6.30%			
Engagement – Alcohol 65+ Years	28	1	3.57%			
Engagement – Opioid Abuse or Dependence 18–64 Years	499	96	19.24%			
Engagement – Opioid Abuse or Dependence 65+ Years	7	1	14.29%			
Engagement – Other Drugs 18–64 Years	572	45	7.87%			
Engagement – Other Drugs 65+ Years	14	0	0.00%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Engagement – Total 18–64 Years	1,321	153	11.58%			
Engagement – Total 65+ Years	49	2	4.08%			
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care				411	69	16.79%
Postpartum Care				411	82	19.95%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	264	155	58.71%			
12–17 Years	326	215	65.95%			
Total 1–17 Years	NR	NR	NR			
Utilization						
Well–Child Visits in the First 30 Months of Life (15 Months–30 Months) (W30)						
First 15 Months	2,959	16	0.54%			
15 Months–30 Months	3,158	359	11.37%			
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	39,203	7,686	19.61%			
12–17 Years	30,233	4,480	14.82%			
18–21 Years	20,109	1,557	7.74%			
Total	89,545	13,723	15.33%			
Ambulatory Care (AMB)						
ED (0–19 Years)	1,142,896	220,106	2311.03			
Outpatient (Total)	3,706,479	666,981	2159.40			
Plan All-Cause Readmission (PCR)	5,998	421	7.0190			

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Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Effectiveness of Care: Prevention and Screening						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile						
3–11 Years	24,865	13,489	54.25%			
12–17 Years	17,434	8,767	50.29%			
Total	42,299	22,256	52.62%			
Counseling for Nutrition						
3–11 Years	24,865	13,094	52.66%			
12–17 Years	17,434	8,823	50.61%			
Total	42,299	21,917	51.81%			
Counseling for Physical Activity						
3–11 Years	24,865	9,255	37.22%			
12–17 Years	17,434	6,536	37.49%			
Total	42,299	15,791	37.33%			
Childhood Immunization Status (CIS)						
DTaP	2,842	1,540	54.19%			
IPV	2,842	1,857	65.34%			
MMR	2,842	2,355	82.86%			
HiB	2,842	2,099	73.86%			
Hepatitis B	2,842	1,646	57.92%			
VZV	2,842	2,326	81.84%			
Pneumococcal Conjugate	2,842	1,457	51.27%			
Hepatitis A	2,842	2,378	83.67%			
Rotavirus	2,842	1,487	52.32%			
Influenza	2,842	433	15.24%			
Combination #2	NR	NR	NR			
Combination #3	2,842	1,237	43.53%			
Combination #4	NR	NR	NR			
Combination #5	NR	NR	NR			
Combination #6	NR	NR	NR			
Combination #7	2,842	1,060	37.30%			
Combination #8	NR	NR	NR			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Combination #9	NR	NR	NR			
Combination #10	2,842	281	9.89%			
Immunizations for Adolescents (IMA)						
Meningococcal	4,709	3,803	80.76%			
Tdap	4,709	3,844	81.63%			
HPV	4,709	2,532	53.77%			
Combination #1	4,709	3,788	80.44%			
Combination #2	4,709	2,513	53.37%			
Lead Screening in Children (LSC)	2,879	933	32.41%			
Breast Cancer Screening (BCS-E)[12]	NR	NR	NR			
Cervical Cancer Screening (CCS)	96,437	47,242	48.99%			
Chlamydia Screening in Women (CHL)						
16–20 Years	3,878	2,622	67.61%			
21–24 Years	4,376	2,812	64.26%			
Total	8,254	5,434	65.83%			
Colorectal Cancer Screening (COL)						
46–50 Years	15,043	4,942	32.85%			
51–75 Years	70,684	36,374	51.46%			
Total	85,727	41,316	48.19%			
Effectiveness of Care: Respiratory Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	540	528	97.78%			
12–18 Years	279	259	92.83%			
19–50 Years	1,534	1,199	78.16%			
51–64 Years	1,544	1,163	75.32%			
Total	3,897	3,149	80.81%			
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)	26,437	15,976	60.43%	388	268	69.07%

[12] MMM indicated that the Breast cancer Screening was not required for reporting; however, the final audit report (FAR) indicates the rate of 63.62%

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Effectiveness of Care: Diabetes						
Hemoglobin A1c Control for Patients With Diabetes (HBD)						
Poor HbA1c Control	26,496	12,751	48.12%	411	171	41.61%
HbA1c Control (<8.0)	26,496	11,624	43.87%	411	212	51.58%
Eye Exam for Patients With Diabetes (EED)						
Eye Exam for Patients With Diabetes	26,496	9,054	34.17%	411	144	35.04%
Kidney Health Valuation for Patients with Diabetes (KED)						
Total	27,672	7,543	27.26%			
Blood Pressure Control for Patients With Diabetes (BPD)						
Blood Pressure Control for Patients With Diabetes	26,496	15,785	59.58%	411	288	70.07%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	4,677	2,415	51.64%			
Effective Continuation Phase Treatment	4,677	1,631	34.87%			
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	631	397	62.92%			
Continuation and Maintenance (C&M) Phase	99	77	77.78%			
Follow-Up After Hospitalization for Mental Illness (FUH)						
6–17 Years — 30-Day Follow-Up	163	134	82.21%			
6–17 Years — 7-Day Follow-Up	163	83	50.92%			
18–64 Years — 30-Day Follow-Up	1,558	1,076	69.06%			
18–64 Years — 7-Day Follow-Up	1,558	725	46.53%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
65+ Years — 30-Day Follow-Up	43	20	46.51%			
65+ Years — 7-Day Follow-Up	43	12	27.91%			
Total — 30-Day Follow-Up	1,764	1,230	69.73%			
Total — 7-Day Follow-Up	1,764	820	46.49%			
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
6–17 Years — 30-Day Follow-Up	74	55	74.32%			
6–17 Years — 7-Day Follow-Up	74	26	35.14%			
18–64 Years — 30-Day Follow-Up	466	239	51.29%			
18–64 Years — 7-Day Follow-Up	466	118	25.32%			
65+ Years — 30-Day Follow-Up	34	18	52.94%			
65+ Years — 7-Day Follow-Up	34	6	17.65%			
Total — 30-Day Follow-Up	574	312	54.36%			
Total — 7-Day Follow-Up	574	150	26.13%			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
30-Day Follow-Up: 13–17 Years	7	1	14.29%			
7-Day Follow-Up: 13–17 Years	7	0	0.00%			
30-Day Follow-Up: 18+ Years	406	101	24.88%			
7-Day Follow-Up: 18+ Years	406	42	10.34%			
30-Day Follow-Up: Total	413	102	24.70%			
7-Day Follow-Up: Total	413	42	10.17%			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	2,408	1,692	70.27%			
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	519	416	80.15%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	2,318	1,776	76.62%			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
1–11 Years	483	274	56.73%			
12–17 Years	811	496	61.16%			
Total	1,294	770	59.51%			
Effectiveness of Care: Overuse/Appropriateness						
Appropriate Treatment for Children with URI (URI)	36,191	11,626	67.88%			
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	4,244	1,841	56.62%			
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20–44 Years	118,379	68,170	57.59%			
45–64 Years	83,774	64,605	77.12%			
65+ Years	22,507	16,893	75.06%			
Total	224,660	149,668	66.62%			
Oral Evaluation, Dental Services (OED)						
2–3 Years	NR	NR	NR			
4–6 Years	NR	NR	NR			
7–10 Years	NR	NR	NR			
11–14 Years	NR	NR	NR			
15–18 Years	NR	NR	NR			
19–20 Years	NR	NR	NR			
Total	90,647	43,812	48.33%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)						
Alcohol abuse or dependence: Initiation of AOD Treatment: 13–17 Years	6	0	0.00%			
Alcohol abuse or dependence: Engagement of AOD Treatment: 13–17 Years	6	0	0.00%			
Opioid abuse or dependence: Initiation of AOD Treatment: 13–17 Years	5	4	80.00%			
Opioid abuse or dependence: Engagement of AOD Treatment: 13–17 Years	5	3	60.00%			
Other drug abuse or dependence: Initiation of AOD Treatment: 13–17 Years	71	31	43.66%			
Other drug abuse or dependence: Engagement of AOD Treatment: 13–17 Years	71	14	19.72%			
Total: Initiation of AOD Treatment: 13–17 Years	82	35	42.68%			
Total: Engagement of AOD Treatment: 13–17 Years	82	17	20.73%			
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	1,501	445	29.65%			
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	1,501	91	6.06%			
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	579	264	45.60%			
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	579	87	15.03%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	2,463	731	29.68%			
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	2,463	163	6.62%			
Total: Initiation of AOD Treatment: 18+ Years	4,543	1,440	31.70%			
Total: Engagement of AOD Treatment: 18+ Years	4,543	341	7.51%			
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	1,507	445	29.53%			
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	1,507	91	6.04%			
Opioid abuse or dependence: Initiation of AOD Treatment: Total	584	268	45.89%			
Opioid abuse or dependence: Engagement of AOD Treatment: Total	584	90	15.41%			
Other drug abuse or dependence: Initiation of AOD Treatment: Total	2,534	762	30.07%			
Other drug abuse or dependence: Engagement of AOD Treatment: Total	2,534	177	6.99%			
Total: Initiation of AOD Treatment: Total	4,625	1,475	31.89%			
Total: Engagement of AOD Treatment: Total	4,625	358	7.74%			
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	2,773	1,648	59.43%	405	284	70.12%
Postpartum Care	2,773	1,226	44.21%	405	251	61.98%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	222	96	43.24%			
12–17 Years	304	151	49.67%			
Total	526	247	46.96%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Utilization						
Well–Child Visits in the First 30 Months of Life (15 Months–30 Months) (W30)						
First 15 Months	2,516	458	18.20%			
15 Months–30 Months	2,679	1,465	54.68%			
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	35,812	21,208	59.22%			
12–17 Years	29,483	14,412	48.88%			
18–21 Years	20,222	6,281	31.06%			
Total	85,517	41,901	49.00%			
Ambulatory Care: Total (AMBA) – OP Visits	3,996,441	1,131,854	3398.59/ 1,000 MMOS			
Ambulatory Care: Total (AMBA) – ED Visits	3,996,441	189,799	569.90/ 1,000 MMOS			
Risk Adjusted Utilization						
Plan All-Cause Readmissions (PCR)	8.09	6.72	0.8307			
Health Plan Descriptive Information						
Enrollment by Product Line: Total (ENPA)	4,001,259	4,001,259	4,001,259			
Measures Collected Using Electronic Clinical Data Systems						
Depression Screening and Follow-Up for Adolescents and Adults (DSF)						
Depression Screening: Total	237,495	36,622	15.42%			
Follow-up on Positive Screen: Total	3,175	2,515	79.21%			
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)						
Utilization of PHQ-9 — Time period 1: Total	13,376	4,489	33.56%			
Utilization of PHQ-9 — Time period 2: Total	13,493	4,012	29.73%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Utilization of PHQ-9 — Time period 3: Total	12,776	3,239	25.35%			
Utilization of PHQ-9 — Total: Total	39,645	11,740	29.61%			
Depression and Remission or Response for Adolescents and Adults (DRR)						
Follow-up PHQ-9: Total	1,930	809	41.92%			
Depression Remission: Total	1,930	297	15.39%			
Depression Response: Total	1,930	443	22.95%			
Unhealthy Alcohol Use Screening and Follow-Up (ASF)						
Alcohol Use Screening: Total	225,473	0	0.00%			
Counseling or Other Follow-up Positive Screen: Total	0	0	0.00%			
Adult Immunization Status (AIS)						
Influenza: Total	224,669	6,787	3.02%			
Td or Tdap: Total	224,669	9,074	4.04%			
Zoster: Total	81,938	265	0.32%			
Pneumococcal	19,014	996	5.24%			
Prenatal Immunization Status (PRS)						
Influenza: Total	2,060	167	8.11%			
Td or Tdap: Total	2,060	234	11.36%			
Combination: Total	2,060	96	4.66%			
Pharmacotherapy for Opioid Use Disorder (POD)	245	85	34.69%			
Topical Fluoride for Children (TFC)	12,071	2	0.02%			
Diagnosed Mental Health Disorders (DMH)	314,018	57,413	18.28%			
Diagnosed Substance Use Disorders (DSU) – Any: Alcohol, Opioid, Other	266,701	5,842	2.19%			

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Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Effectiveness of Care: Prevention and Screening						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile						
3–11 Years	15,787	9,191	58.22%			
12–17 Years	10,666	6,100	57.19%			
Total	26,453	15,291	57.80%			
Counseling for Nutrition						
3–11 Years	15,787	8,221	52.07%			
12–17 Years	10,666	5,378	50.42%			
Total	26,453	13,599	51.41%			
Counseling for Physical Activity						
3–11 Years	15,787	5,637	35.71%			
12–17 Years	10,666	3,714	34.82%			
Total	26,453	9,351	35.35%			
Childhood Immunization Status (CIS)						
DTaP	2,188	379	17.32%			
IPV	2,188	473	21.62%			
MMR	2,188	1,490	68.10%			
HiB	2,188	914	41.77%			
Hepatitis B	2,188	138	6.31%			
VZV	2,188	1,478	67.55%			
Pneumococcal Conjugate	2,188	362	16.54%			
Hepatitis A	2,188	1,649	75.37%			
Rotavirus	2,188	314	14.35%			
Influenza	2,188	239	10.92%			
Combination #2	NR	NR	NR			
Combination #3	2,188	83	3.79%			
Combination #4	NR	NR	NR			
Combination #5	NR	NR	NR			
Combination #6	NR	NR	NR			
Combination #7	2,188	46	2.10%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Combination #8	NR	NR	NR			
Combination #9	NR	NR	NR			
Combination #10	2,188	13	0.59%			
Immunizations for Adolescents (IMA)						
Meningococcal	2,975	1,623	54.55%			
Tdap	2,975	1,652	55.53%			
HPV	2,975	963	32.37%			
Combination #1	2,975	1,583	53.21%			
Combination #2	2,975	921	30.96%			
Lead Screening in Children (LSC)	2,194	778	35.46%			
Breast Cancer Screening (BCS-E)	13,644	9,296	68.13%			
Cervical Cancer Screening (CCS)	51,482	28,437	55.24%			
Chlamydia Screening in Women (CHL)						
16–20 Years	2,423	1,541	63.60%			
21–24 Years	3,002	2,102	70.02%			
Total	5,425	3,643	67.15%			
Colorectal Cancer Screening (COL)						
46–50 Years	9,344	2,783	29.78%			
51–75 Years	26,512	12,814	48.33%			
Total	35,856	15,597	43.50%			
Effectiveness of Care: Respiratory Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	602	578	96.01%			
12–18 Years	312	288	92.31%			
19–50 Years	1,251	1,010	80.74%			
51–64 Years	1,006	790	78.53%			
Total	3,171	2,666	84.07%			
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)	16,752	9,487	56.63%	411	237	57.66%

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Effectiveness of Care: Diabetes						
Hemoglobin A1c (HbA1c) Testing (HBD)						
Poor HbA1c Poor Control	12,172	8,608	70.72%	411	267	64.96%
HbA1c Control (<8.0%)	12,172	3,098	25.45%	411	122	29.68%
Eye Exam for Patients with Diabetes (EED)	12,172	3,976	32.67%	411	148	36.01%
Blood Pressure Control for Patients with Diabetes (BPD)	12,172	6,722	55.23%	411	188	54.26%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	2,704	1,577	58.32%			
Effective Continuation Phase Treatment	2,704	1,144	42.31%			
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	426	221	51.88%			
Continuation and Maintenance (C&M) Phase	86	52	60.47%			
Follow-Up After Hospitalization for Mental Illness (FUH)						
6–17 Years — 30-Day Follow-Up	336	253	75.30%			
6–17 Years — 7-Day Follow-Up	336	127	37.80%			
18–64 Years — 30-Day Follow-Up	781	526	67.35%			
18–64 Years — 7-Day Follow-Up	781	277	35.47%			
65+ Years — 30-Day Follow-Up	17	8	47.06%			
65+ Years — 7-Day Follow-Up	17	5	29.41%			
Total — 30-Day Follow-Up	1,134	787	69.40%			
Total — 7-Day Follow-Up	1,134	409	36.07%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
6–17 Years — 30-Day Follow-Up	22	14	63.64%			
6–17 Years — 7-Day Follow-Up	22	10	45.45%			
18–64 Years — 30-Day Follow-Up	145	70	48.28%			
18–64 Years — 7-Day Follow-Up	145	50	34.48%			
65+ Years — 30-Day Follow-Up	15	10	66.67%			
65+ Years — 7-Day Follow-Up	15	6	40.00%			
Total — 30-Day Follow-Up	182	94	51.65%			
Total — 7-Day Follow-Up	182	66	36.26%			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
30-Day Follow-Up: 13–17 Years	5	2	40.00%			
7-Day Follow-Up: 13–17 Years	5	1	20.00%			
30-Day Follow-Up: 18+ Years	156	26	16.67%			
7-Day Follow-Up: 18+ Years	156	20	12.82%			
30-Day Follow-Up: Total	161	28	17.39%			
7-Day Follow-Up: Total	161	21	13.04%			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	728	511	70.19%			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	614	442	71.99%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
1–11 Years	231	107	46.32%			
12–17 Years	283	156	55.12%			
Total	514	263	51.17%			
Effectiveness of Care: Overuse/Appropriateness						
Appropriate Treatment for Children with URI (URI)	37,465	11,864	68.33%			
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	4,392	1,941	55.81%			
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20–44 Years	66,047	42228	63.94%			
45–64 Years	36,075	28874	80.04%			
65+ Years	8,356	6,442	77.09%			
Total	110,478	77,544	70.19%			
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)						
Alcohol abuse or dependence: Initiation of AOD Treatment: 13–17 Years	2	1	50.00%			
Alcohol abuse or dependence: Engagement of AOD Treatment: 13–17 Years	2	0	0.00%			
Opioid abuse or dependence: Initiation of AOD Treatment: 13–17 Years	0	0	NA			
Opioid abuse or dependence: Engagement of AOD Treatment: 13–17 Years	0	0	NA			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Other drug abuse or dependence: Initiation of AOD Treatment: 13–17 Years	46	15	32.61%			
Other drug abuse or dependence: Engagement of AOD Treatment: 13–17 Years	46	2	4.35%			
Total: Initiation of AOD Treatment: 13–17 Years	48	16	33.33%			
Total: Engagement of AOD Treatment: 13–17 Years	48	2	4.17%			
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	610	187	30.66%			
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	610	44	7.21%			
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	259	121	46.72%			
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	259	40	15.44%			
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	982	292	29.74%			
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	982	38	3.87%			
Total: Initiation of AOD Treatment: 18+ Years	1,851	600	32.41%			
Total: Engagement of AOD Treatment: 18+ Years	1,851	168	9.08%			
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	612	188	30.72%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	612	44	7.19%			
Opioid abuse or dependence: Initiation of AOD Treatment: Total	259	121	46.72%			
Opioid abuse or dependence: Engagement of AOD Treatment: Total	259	40	15.44%			
Other drug abuse or dependence: Initiation of AOD Treatment: Total	1,028	307	29.86%			
Other drug abuse or dependence: Engagement of AOD Treatment: Total	353	40	11.33%			
Total: Initiation of AOD Treatment: Total	1,899	616	32.44%			
Total: Engagement of AOD Treatment: Total	1,899	170	8.95%			
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	1,974	793	40.17%	411	168	40.88%
Postpartum Care	1,974	587	29.74%	411	116	28.22%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	117	63	53.85%			
12–17 Years	132	62	46.97%			
Total	249	125	50.20%			
Utilization						
Well–Child Visits in the First 30 Months of Life (15 Months–30 Months) (W30)						
First 15 Months	2,001	296	14.79%			
15 Months–30 Months	2,240	995	44.42%			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	22,594	11,824	52.33%			
12–17 Years	18,328	8,043	43.88%			
18–21 Years	12,473	3,762	30.16%			
Total	53,395	23,629	44.25%			
Ambulatory Care: Total (AMBA)	2,116,268	853,792	403.44			
Risk Adjusted Utilization						
Plan All-Cause Readmissions (PCR)	5,081	361	7.10			
Measures Collected Using Electronic Clinical Data Systems						
Kidney Health Evaluation for Patients with Diabetes						
18–64 Years	10,302	*2,089*	20.28%			
65–74 Years	1,512	*312*	20.63%			
75–85 Years	854	*183*	21.43%			
Total	12,668	*2,584*	20.40%			
Diagnosed Mental Health Disorders (DMH)						
1–17 Years	45,201	8,934	19.77%			
18–64 Years	108,528	18,252	16.82%			
65+ Years	8,356	1,684	20.15%			
Total	162,085	28,870	17.81%			
Diagnosed Substance Use Disorder (DSU)						
Alcohol (Total)	132,240	875	0.66%			
Opioid (Total)	132,240	610	0.46%			
Other (Total)	132,240	1,567	1.18%			
Any (Total)	132,240	2,450	1.85%			

Triple-S

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Effectiveness of Care: Prevention and Screening						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile						
3–11 Years	36,316	13,615	37.49			
12–17 Years	25,078	9,654	38.5			
Total	61,394	23,269	37.9			
Counseling for Nutrition						
3–11 Years	36,316	9,925	27.33			
12–17 Years	25,078	6,954	27.73			
Total	61,394	16,879	27.49			
Counseling for Physical Activity						
3–11 Years	36,316	7,315	20.14			
12–17 Years	25,078	5,565	22.19			
Total	61,394	12,880	20.98			
Childhood Immunization Status (CIS)						
DTaP	4,609	927	20.11			
IPV	4,609	1,310	28.42			
MMR	4,609	3,162	68.6			
HiB	4,609	2107	45.71			
Hepatitis B	4,609	394	8.55			
VZV	4,609	3131	67.93			
Pneumococcal Conjugate	4,609	929	20.16			
Hepatitis A	4,609	3033	65.81			
Rotavirus	4,609	869	18.85			
Influenza	4,609	453	9.83			
Combination #2	NQ	NQ	NQ			
Combination #3	4,609	219	4.75			
Combination #4	NQ	NQ	NQ			
Combination #5	NQ	NQ	NQ			
Combination #6	NQ	NQ	NQ			
Combination #7	4,609	117	2.54			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Combination #8	NQ	NQ	NQ			
Combination #9	NQ	NQ	NQ			
Combination #10	4,609	17	0.37			
Immunizations for Adolescents (IMA)						
Meningococcal	6,976	4,289	61.48			
Tdap	6,976	4,295	61.57			
HPV	6,976	2,647	31.94			
Combination #1	6,976	4,182	59.95			
Combination #2	6,976	2,558	36.67			
Breast Cancer Screening (BCS-E)	42,936	27,528	64.11			
Cervical Cancer Screening (CCS)				411	207	50.36
Chlamydia Screening in Women (CHL)						
16-20 Years	5,142	3,231	62.84			
21-24 Years	6,485	4,205	64.84			
Total	11,627	7,436	63.95			
Colorectal Cancer Screening (COL)						
46-50 Years	26,472	7,147	34.29			
51-75 Years	83,812	43,314	49.38			
Total	110,284	50,462	45.76			
Effectiveness of Care: Respiratory Conditions						
Asthma Medication Ratio (AMR)						
5-11 Years	770	748	97.14			
12-18 Years	449	421	93.76			
19-50 Years	2,579	2,007	77.82			
51-64 Years	2,081	1,590	76.41			
Total	5,879	4,766	81.07			
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)				*380*	*208*	54.74
Effectiveness of Care: Diabetes						
Hemoglobin A1c (HbA1c) Testing (HBD)						
HbA1c Poor Control				411	240	58.39
HbA1c Control (<8.0%)				411	146	35.52

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Eye Exam for Patients With Diabetes (EED)				411	158	38.44
Blood Pressure Control for Patients With Diabetes (BPD)				411	202	49.15
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	16,516	3,472	48.87			
Effective Continuation Phase Treatment	16,516	2,305	32.44			
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	1,192	554	46.48			
Continuation and Maintenance (C&M) Phase	184	117	63.59			
Follow-Up After Hospitalization for Mental Illness (FUH)						
6–17 Years – 30-Day Follow-Up	559	405	72.45			
6–17 Years – 7-Day Follow-Up	559	179	32.02			
18–64 Years – 30-Day Follow-Up	2,159	1,243	57.57			
18–64 Years – 7-Day Follow-Up	2,159	552	25.57			
65+ Years – 30-Day Follow-Up	54	27	50			
65+ Years – 7-Day Follow-Up	54	9	16.67			
Total – 30-Day Follow-Up	2,772	1,675	60.43			
Total – 7-Day Follow-Up	2,772	740	26.7			
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
6–17 Years – 30-Day Follow-Up	54	36	66.67			
6–17 Years – 7-Day Follow-Up	54	31	57.41			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
18–64 Years – 30-Day Follow-Up	335	151	45.07			
18–64 Years – 7-Day Follow-Up	335	68	20.3			
65+ Years – 30-Day Follow-Up	33	15	45.45			
65+ Years – 7-Day Follow-Up	33	3	9.09			
Total – 30-Day Follow-Up	422	202	47.87			
Total – 7-Day Follow-Up	422	102	24.17			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
30-Day Follow-Up: 13–17 Years	10	3	30			
7-Day Follow-Up: 13–17 Years	10	1	10			
30-Day Follow-Up: 18+ Years	464	120	25.86			
7-Day Follow-Up: 18+ Years	464	73	15.73			
30-Day Follow-Up: Total	474	123	25.95			
7-Day Follow-Up: Total	474	74	15.61			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	2,908	2,164	74.42			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	25.1	1,907	75.98			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
1–5 Years	32	13	40.63			
6–11 Years	461	216	46.85			
12–17 Years	683	371	54.32			
Total	1,176	600	51.02			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Effectiveness of Care: Overuse/Appropriateness						
Appropriate Treatment for Children With URI (URI)	80,299	26,648	66.81			
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	8,329	3,664	56.01			
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20–44 Years	181,083	111,896	61.79			
45-64 Years	111,022	86,623	78.02			
65+ Years	23,076	18,244	79.06			
Total	315,181	216,763	68.77			
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)						
Alcohol abuse or dependence: Initiation of AOD Treatment: 13–17 Years	11	3	27.27			
Alcohol abuse or dependence: Engagement of AOD Treatment: 13–17 Years	11	1	9.09			
Opioid abuse or dependence: Initiation of AOD Treatment: 13–17 Years	3	2	66.67			
Opioid abuse or dependence: Engagement of AOD Treatment: 13–17 Years	3	1	33.33			
Other drug abuse or dependence: Initiation of AOD Treatment: 13–17 Years	90	22	24.44			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Other drug abuse or dependence: Engagement of AOD Treatment: 13–17 Years	90	7	7.78			
Total: Initiation of AOD Treatment: 13-17 Years	104	27	25.96			
Total: Engagement of AOD Treatment: 13–17 Years	104	9	8.65			
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	1,680	492	29.29			
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	1,680	95	5.65			
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	908	469	51.65			
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	908	164	18.06			
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	3,231	1,077	33.33			
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	3,231	264	8.17			
Total: Initiation of AOD Treatment: 18+ Years	5,819	2,038	35.02			
Total: Engagement of AOD Treatment: 18+ Years	5,819	523	8.99			
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	1,887	520	27.56			
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	1,887	100	5.3			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Opioid abuse or dependence: Initiation of AOD Treatment: Total	940	479	50.96			
Opioid abuse or dependence: Engagement of AOD Treatment: Total	940	167	17.77			
Other drug abuse or dependence: Initiation of AOD Treatment: Total	3,448	1,111	32.22			
Other drug abuse or dependence: Engagement of AOD Treatment: Total	3,448	274	7.95			
Total: Initiation of AOD Treatment: Total	6,275	2,110	33.63			
Total: Engagement of AOD Treatment: Total	6,275	541	8.62			
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care				411	320	77.86
Postpartum Care				411	224	54.5
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–5 Years	18	6	33.33			
6–11 Years	206	125	60.68			
12–17 Years	306	171	55.88			
Total	530	302	56.98			
Utilization						
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months) (W30)						
First 15 Months	4,206	399	9.49			
15 Months–30 Months	4,586	1,926	42			
Child and Adolescent Well-Care Visits (WCV)						
3-11 Years	53,431	26,219	49.07			
12-17 Years	42,753	17,859	41.77			
18-21 Years	28,455	8,056	28.31			
Total	124,639	52,134	41.83			

Measure/Data Element	Admin Denominator	Admin Numerator	Admin Reported Rate	Hybrid Denominator	Hybrid Numerator	Hybrid Reported Rate
Ambulatory Care: Total (AMBA)	5,691,876	2,063,889	36.26			
Risk Adjusted Utilization						
Plan All-Cause Readmissions (pcr)	15,467	1,149	0.8976			
Health Plan Descriptive Information						
Enrollment by Product Line: Total (ENPA)	5,692,347		474362			
Measures Collected using Electronic Clinical Data Systems						
Kidney Health Evaluation for Patients With Diabetes (KED)						
18–64 Years	30,035	8,009	26.67			
65–74 Years	3,990	1,104	27.67			
75–85 Years	2,199	592	26.92			
Total	36,224	9,705	26.79			
Diagnosed Substance Use Disorders (DSU)						
Alcohol: 13–17 Years	36,530	12	0.03			
Alcohol: 18–64 Years	320,417	2,410	0.75			
Alcohol: 65+ Years	24,421	303	1.19			
Alcohol Total	381,368	2,725	0.71			
Opioid: 13–17 Years	36,530	2	0.01			
Opioid: 18–64 Years	320,417	2,084	0.65			
Opioid: 65+ Years	24,421	77	0.26			
Opioid Total	381,368	2,163	0.56			
Other: 13–17 Years	36,530	87	0.24			
Other: 18–64 Years	320,417	4,997	1.56			
Other: 65+ Years	24,421	239	0.93			
Other: Total	381,368	5,323	1.39			
Any: 13–17 Years	36,530	94	0.26			
Any: 18–64 Years	320,417	7,444	2.32			
Any: 65+ Years	24,421	551	2.2			
Any Total	381,368	8,066	2.12			

Appendix D
Platino Reported PM Rates

Introduction

MAOs were required to report their CY 2023 HEDIS measure rates. Below is a summary of the rates.

Humana

Measure/Data Element	Program 1 HEDIS Rate H4007 HMO	Program 2 HEDIS Rate H4007-016	Program 3 HEDIS Rate H4007 018	Program 4 HEDIS Rate H4007-019	Program 5 HEDIS Rate H4007-022
Effectiveness of Care: Prevention and Screening					
Colorectal Cancer Screening (COL) *Total*					
46–49 Years	NR	NR	NR	NR	NR
50–75 Years	NR	NR	NR	NR	NR
Total	**87.35%**	**84.75%**	**87.77%**	**87.67%**	**84.31%**
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	33.01%	28.75%	35.29%	45.45%	17.39%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	40.74%	34.62%	55.56%	27.27%	36.36%
Bronchodilator	76.85%	65.38%	91.67%	81.82%	63.64%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBP)	85.89%	80.86%	83.22%	83.30%	80.90%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	82.50%	66.67%	88.89%	100.00%	100.00%

Measure/Data Element	Program 1 HEDIS Rate H4007 HMO	Program 2 HEDIS Rate H4007-016	Program 3 HEDIS Rate H4007 018	Program 4 HEDIS Rate H4007-019	Program 5 HEDIS Rate H4007-022
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	68.49%	69.40%	67.70%	69.52%	66.18%
Effective Continuation Phase Treatment	50.06%	51.49%	48.64%	47.62%	48.53%
Follow-Up After Hospitalization for Mental Illness (FUH)					
6–17 years – 30-Day Follow-Up	NR	NR	NR	NR	NR
6–17 years – 7-Day Follow-Up	NR	NR	NR	NR	NR
18–64 years – 30-Day Follow-Up	NR	NR	NR	NR	NR
18–64 years – 7-Day Follow-Up	NR	NR	NR	NR	NR
65+ years – 30-Day Follow-Up	NR	NR	NR	NR	NR
65+ years – 7-Day Follow-Up	NR	NR	NR	NR	NR
Total — 30-Day Follow-Up	**74.44%**	**81.82%**	**71.43%**	**83.33%**	**56.25%**
Total — 7-Day Follow-Up	**56.67%**	**72.73%**	**53.57%**	**66.67%**	**37.50%**
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)					
Plan All Cause Readmissions 18–64	9.76%	14.44%	10.90%	1.67%	8.16%
Plan All Cause Readmissions 65+	10.20%	9.84%	9.32%	7.91%	10.91%
Total	**NR**	**NR**	**NR**	**NR**	**NR**

Measure/Data Element	Program 1 HEDIS Rate H4007 HMO	Program 2 HEDIS Rate H4007-016	Program 3 HEDIS Rate H4007 018	Program 4 HEDIS Rate H4007-019	Program 5 HEDIS Rate H4007-022
Additional Measures					
Care for Older Adults (COA)					
Medication Review	NQ	96.11%	95.86%	96.84%	93.43%
Functional Status Assessment	NQ	96.35%	95.90%	97.81%	96.84%
Pain Assessment	NQ	97.57%	96.59%	98.30%	97.57%
Use of High-Risk Medications in Older Adults (DAE)					
High-Risk Medications to Avoid	18.58%	19.21%	21.50%	22.87%	18.61%
Except for Appropriate Diagnosis	10.80%	13.16%	11.53%	11.93%	10.57%
Total	**26.34%**	**28.65%**	**29.27%**	**30.78%**	**26.97%**
Osteoporosis Management in Women Who Had a Fracture (OMW)	84.38%	100.00%	90.91%	66.67%	100%
Transitions of Care (TRC)					
Transitions of Care – Notification of Inpatient Admission (Total)	25.06%	7.54%	7.79%	3.14%	6.70%
Transitions of Care – Receipt of Discharge Information (Total)	0.73%	0.24%	0.49%	0.00%	0.00%
Transitions of Care – Patient Engagement After Inpatient Discharge (Total)	85.64%	82.48%	84.18%	86.41%	83.25%
Transitions of Care – Medication Reconciliation Post-Discharge (Total)	85.16%	84.91%	83.21%	81.88%	74.64%

Measure/Data Element	Program 1 HEDIS Rate H4007 HMO	Program 2 HEDIS Rate H4007-016	Program 3 HEDIS Rate H4007 018	Program 4 HEDIS Rate H4007-019	Program 5 HEDIS Rate H4007-022
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)					
Potentially Harmful Drug-Disease Interactions in Older Adults – DDI – History of Falls	48.65%	46.85%	53.03%	64.41%	41.94%
Potentially Harmful Drug-Disease Interactions in Older Adults – DDI – Dementia	50.07%	48.92%	49.20%	55.03%	61.19%
Potentially Harmful Drug-Disease Interactions in Older Adults – DDI – Chronic Kidney Disease	25.50%	24.16%	24.15%	35.23%	27.78%
Potentially Harmful Drug-Disease Interactions in Older Adults – DDI (Total)	43.52%	41.34%	43.17%	51.01%	47.76%

MCS

Measure/Data Element	Sub ID: 8881	Sub ID: 8882	Sub ID: 13181	Sub ID: 14108	Sub ID: 14902	Sub ID: 16262
Effectiveness of Care: Prevention and Screening						
Colorectal Cancer Screening (col)						
46–49 Years	73.35%	*75%*	83.33%	63.64%	0%	80%
50–75 Years	87.32%	*92.05%*	91.50%	85.95%	84.80%	90.60%
Total	**86.89%**	***91.30%***	**91.19%**	**84.69%**	**84.30%**	**89.94%**
Effectiveness of Care: Respiratory Conditions						
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	37.68%	32.03%	34.45%	34.02%	39.29%	38.78%
Pharmacotherapy Management of COPD Exacerbation (pce)						
Systemic Corticosteroid	47.88%	*50.85%*	47.98%	44.62%	37.74%	51.28%
Bronchodilator	53.91%	*60.68%*	62.33%	57.95%	39.62%	46.15%
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (cbp)	93.67%	95.24%	95.11%	91.28%	91.84%	88.95%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	71.17%	70.37%	83.33%	65.38%	62.50%	83.33%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)						
Effective Acute Phase Treatment	70.68%	*71.32%*	71.80%	70.82%	74.84%	78.50%
Effective Continuation Phase Treatment	51.73%	*52.36%*	53.28%	52.09%	42.14%	56.50%

Measure/Data Element	Sub ID: 8881	Sub ID: 8882	Sub ID: 13181	Sub ID: 14108	Sub ID: 14902	Sub ID: 16262
Follow-Up After Hospitalization for Mental Illness (fuh)						
6–17 Years — 30-Day Follow-Up	0%	0%	0%	0%	0%	0%
6–17 Years — 7-Day Follow-Up	0%	0%	0%	0%	0%	0%
18–64 Years — 30-Day Follow-Up	*75.88%*	*80.99%*	79.31%	73.37%	45.45%	87.76%
18–64 Years — 7-Day Follow-Up	*42.40%*	*43.66%*	48.28%	37.87%	36.36%	57.14%
65+ Years — 30-Day Follow-Up	*72.42%*	*74.07%*	72.22%	76%	56.52%	94.12%
65+ Years — 7-Day Follow-Up	*35.94%*	*35.80%*	34.72%	42.67%	34.78%	29.41%
Total — 30-Day Follow-Up	**74.42%**	***78.48%***	**76.60%**	**74.18%**	**52.94**	**89.39%**
Total — 7-Day Follow-Up	**39.76%**	***40.81%***	**43.09%**	**39.34%**	**35.29%**	**50%**
Risk Adjusted Utilization						
Plan All-Cause Readmissions (pcr)						
Plan All Cause Readmissions 18–64	NR	NR	NR	NR	NR	NR
Plan All Cause Readmissions 65+	NR	NR	NR	NR	NR	NR
Total	**9.67%**	**10.78%**	**9.42%**	**9.45%**	**9.98%**	**11.70%**
Additional Measures						
Care for Older Adults (COA) SNP Only						
Medication Review	NR	99.03%	99.03%	98.54%	99.27%	99.27%
Functional Status Assessment	NR	98.30%	98.78%	98.05%	98.54%	99.03%
Pain Assessment	NR	99.27%	99.03%	98.05%	98.54%	99.27%

Measure/Data Element	Sub ID: 8881	Sub ID: 8882	Sub ID: 13181	Sub ID: 14108	Sub ID: 14902	Sub ID: 16262
Use of High-Risk Medications in Older Adults (DAE)						
High Risk Medications to Avoid	14.81%	16.71%	16.96%	17.18%	19.94%	19.4%
Except Appropriate Diagnosis	11.49%	12.54%	13.03%	12.2%	10.28%	16.56%
Total	**23.95%**	**26.38%**	**26.99%**	**26.29%**	**27.99%**	**32.4%**
Osteoporosis Management in Women Who Had a Fracture (OMW)	85.64%	90.91%	90.41%	92.86%	87.5%	100%
Transitions of Care (TRC)						
Notification Inpatient Admission 18–64 Years	94.92%	74.44%	73.68%	81.65%	75%	76.98%
Notification Inpatient Admission 65+ Years	96.88%	86.29%	86.72%	84.44%	82.85%	84.21%
Notification Inpatient Admission Total	96.59%	83.7%	84.91%	83.7%	82.24%	82%
Medication Reconciliation Post Discharge 18–64 Years	84.75%	82.22%	85.96%	85.32%	93.75%	78.57%
Medication Reconciliation Post Discharge 65+ Years	88.07%	86.92%	86.16%	86.09%	88.39%	89.12%
Medication Reconciliation Post Discharge Total	87.59%	85.89%	86.13%	85.89%	88.81%	85.89%
Patient Engagement After Inpatient Discharge 18–64 Years	91.53%	92.22%	94.74%	91.74%	87.5%	90.48%
Patient Engagement After Inpatient Discharge 65+ Years	93.18%	92.52%	94.35%	94.37%	88.92%	94.04%
Patient Engagement After Inpatient Discharge Total	92.94%	92.46%	94.4%	93.67%	88.81%	92.94%

Measure/Data Element	Sub ID: 8881	Sub ID: 8882	Sub ID: 13181	Sub ID: 14108	Sub ID: 14902	Sub ID: 16262
Receipt Discharge Information 18–64 Years	38.98%	16.67%	7.02%	20.18%	21.88%	17.46%
Receipt Discharge Information 65+ Years	32.95%	17.45%	16.1%	15.89%	19%	13.68%
Receipt Discharge Information Total	33.82%	17.27%	14.84%	17.03%	19.22%	14.84%
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)						
History of Falls	51.80%	52.08%	55.7%	54.06%	49.38%	60.78%
Dementia	51.62%	52.64%	52.57%	55.05%	50.44%	59.13%
Chronic Kidney Disease	25.88%	26.13%	28.66%	31.3%	24.82%	25.69%
Total	**47.09%**	**47.06%**	**48.27%**	**49.6%**	**45.53%**	**52.88%**

MMM Platino

Measure/Data Element	HMY23 H4003_017	HMY23 H4003_049	HMY23 H4003_058	HMY23 H4004_048	HMY23 H4004_062
Effectiveness of Care: Prevention and Screening					
Colorectal Cancer Screening (COL)					
46–50 Years	75.00%	60.00%	85.71%	66.67%	72.08%
51–75 Years	91.54%	89.34%	97.85%	89.09%	91.27%
Total	**91.04%**	**87.92%**	**97.00%**	**88.21%**	**90.67%**
Effectiveness of Care: Respiratory Conditions					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	25.96%	22.50%	19.05%	12.72%	28.46%
Pharmacotherapy Management of COPD Exacerbation (PCE)					
Systemic Corticosteroid	52.48%	53.95%	62.50%	46.94%	52.16%
Bronchodilator	78.35%	76.32%	87.50%	71.43%	79.31%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (CBH)	91.16%	94.56%	93.28%	96.23%	91.79%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	73.68%	70.59%	NA	33.33%	78.57%
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	66.28%	64.55%	73.44%	82.14%	67.44%
Effective Continuation Phase Treatment	48.55%	46.07%	56.25%	61.07%	48.29%
Follow-Up After Hospitalization for Mental Illness (FUH)					
6–17 Years — 30-Day Follow-Up	NA	NA	NA	NA	NA
6–17 Years — 7-Day Follow-Up	NA	NA	NA	NA	NA
18–64 Years — 30-Day Follow-Up	79.39%	72.65%	62.50%	73.91%	78.01%

Measure/Data Element	HMY23 H4003_017	HMY23 H4003_049	HMY23 H4003_058	HMY23 H4004_048	HMY23 H4004_062
18–64 years — 7-Day Follow-Up	44.30%	39.32%	12.50%	43.48%	43.15%
65+ years — 30-Day Follow-Up	74.55%	84.78%	66.67%	64.1%	72.31%
65+ years — 7-Day Follow-Up	50.30%	52.17%	50.00%	33.33%	44.62%
Total — 30-Day Follow-Up	**77.35%**	**76.07%**	**63.64%**	**67.74%**	**76.01%**
Total — 7-Day Follow-Up	**46.82%**	**42.94%**	**22.73%**	**37.1%**	**43.67%**
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)					
Plan All Cause Readmissions 18–64	NR	NR	NR	NR	NR
Plan All Cause Readmissions 65+	NR	NR	NR	NR	NR
Total	**0.92%**	**0.97%**	**0.19%**	**0.98%**	**0.93%**
Additional Measures					
Care for Older Adults (COA)					
Medication Review	100.00%	98.00%	99.13%	99.00%	100.00%
Functional Status Assessment	99.00%	98.00%	99.23%	99.00%	99.00%
Pain Assessment	100.00%	98.00%	99.23%	99.00%	100.00%
Use of High-Risk Medications in Older Adults (DAE)					
High-Risk Medications to Avoid	18.53%	16.29%	23.47%	18.66%	18.37%
Except for Appropriate Diagnosis	12.21%	9.46%	11.90%	17.96%	10.67%
Total	**27.58%**	**23.61%**	**32.15%**	**33.21%**	**26.25%**
Osteoporosis Management in Women Who Had a Fracture (OMW)	81.03%	88.89%	NA	85.71%	94.23%
Transitions of Care (TRC)					
Notification Inpatient Admission 18–64 Years	NR	NR	NR	NR	NR
Notification Inpatient Admission 65+	NR	NR	NR	NR	NR
Notification of Inpatient Admission (Total)	12.65%	10.71%	14.72%	12.17%	9.98%
Medication Reconciliation Post Discharge 18–64 Years	NR	NR	NR	NR	NR

Measure/Data Element	HMY23 H4003_017	HMY23 H4003_049	HMY23 H4003_058	HMY23 H4004_048	HMY23 H4004_062
Medication Reconciliation Post Discharge 65+	NR	NR	NR	NR	NR
Medication Reconciliation Post-Discharge (Total)	91.73%	85.37%	88.68%	88.80%	88.81%
Patient Engagement After Inpatient Discharge 18–64 Years	NR	NR	NR	NR	NR
Patient Engagement After Inpatient Discharge 65+ Years	NR	NR	NR	NR	NR
Patient Engagement After Inpatient Discharge (Total)	94.89%	92.70%	93.21%	94.40%	93.67%
Receipt Discharge Information 18–64 Years	NR	NR	NR	NR	NR
Receipt Discharge Information 65+ Years	NR	NR	NR	NR	NR
Receipt of Discharge Information (Total)	6.33%	7.06%	9.81%	7.30%	5.11%
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)					
History of Falls	51.58%	49.55%	42.86%	52.03%	51.29%
Dementia	50.28%	50.07%	51.43%	51.33%	51.79%
Chronic Kidney Disease	26.64%	26.65%	50.00%	21.10%	27.77%
Total	**44.90%**	**43.90%**	**50.00%**	**45.04%**	**45.70%**

Triple-S Platino

Measure/Data Element	SNP PlanID 022	SNP PlanID 024	SNP PlanID 026	SNP PlanID 028	SNP PlanID 035	SNP PlanID 036
Effectiveness of Care: Prevention and Screening						
Colorectal Cancer Screening (COL)						
46–50 Years	83.33%	90%	66.67%	70%	50%	75%
51–75 Years	80.86%	90.8%	84.65%	90.43%	85.17%	92.26%
Total	**80.88%**	**90.76%**	**84.23%**	**89.5%**	**82.94%**	**91.82%**
Effectiveness of Care: Respiratory Conditions						
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	29.73%	30.94%	38.6%	29.45%	21.43%	38.1%
Pharmacotherapy Management of COPD Exacerbation (PCE)						
Systemic Corticosteroid	71.43%	50%	61.54%	47.22%	66.67%	38.1%
Bronchodilator	71.43%	75.96%	84.62%	69.44%	66.67%	83.33%
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (CBP)	82.43%	88.08%	82.31%	85.56%	87.5%	85.83%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	25%	66.67%	0%	66.67%	0%	87.5%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	68.25%	66.98%	63.08%	69.26%	69.09%	66.81%
Effective Continuation Phase Treatment	46.03%	46.3%	50%	52.36%	49.09%	49.02%
Follow-Up After Hospitalization for Mental Illness (FUH)						
6–17 Years –- 30-Day Follow-Up	0%	0%	0%	0%	0%	0%
6–17 Years – 7-Day Follow-Up	0%	0%	0%	0%	0%	0%
18–64 Years – 30-Day Follow-Up	50%	87.27%	57.58%	64%	55.56%	74.53%
18–64 Years – 7-Day Follow-Up	0%	47.27%	21.21%	26%	33.33%	43.4%
65+ Years – 30-Day Follow-Up	100%	61.29%	61.54%	42.86%	85.71%	71.43%
65+ Years – 7-Day Follow-Up	75%	22.58%	30.77%	21.43%	0%	50%
Total – 30-Day Follow-Up	**75%**	**77.91%**	**58.7%**	**59.38%**	**68.75%**	**73.88%**
Total – 7-Day Follow-Up	**37.5%**	**38.37%**	**23.91%**	**25%**	**18.75%**	**44.78%**

Measure/Data Element	SNP PlanID 022	SNP PlanID 024	SNP PlanID 026	SNP PlanID 028	SNP PlanID 035	SNP PlanID 036
Risk Adjusted Utilization						
Plan All-Cause Readmissions (PCR)						
Plan All Cause Readmissions 18–64	NR	NR	NR	NR	NR	NR
Plan All Cause Readmissions 65+	NR	NR	NR	NR	NR	NR
Total	**1.22%**	**0.98%**	**1.25%**	**1.07%**	**0.97%**	**0.89%**
Additional Measures						
Care for Older Adults (COA)						
Medication Review	98%	100%	99%	100%	99%	100%
Functional Status Assessment	98%	100%	99%	100%	99%	100%
Pain Assessment	98%	100%	99%	100%	99%	100%
Use of High-Risk Medications in Older Adults (DAE)						
High Risk Medications to Avoid	23.55%	22.57%	18.81%	21.85%	33.33%	25.89%
Except Appropriate Diagnosis	8.89%	12.69%	13.86%	11.27%	17.58%	12.04%
Total	**29.34%**	**31.8%**	**29.87%**	**30.12%**	**43.84%**	**34.15%**
Osteoporosis Management in Women Who Had a Fracture (OMW)	75%	80%	100%	90.91%	0%	100%
Transitions of Care (TRC)						
Notification Inpatient Admission 18–64 years	42.86%	37.63%	26.81%	37.93%	35.29%	39.1%
Notification Inpatient Admission 65+	38.17%	35.53%	35.16%	42.37%	35.61%	47.48%
Notification Inpatient Admission Total	38.66%	36.01%	32.36%	41.12%	35.52%	44.77%
Medication Reconciliation Post Discharge 18–64 Years	78.57%	81.72%	63.77%	79.31%	78.43%	84.21%
Medication Reconciliation Post Discharge 65+	80.91%	81.76%	76.92%	86.1%	81.82%	85.25%
Medication Reconciliation Post Discharge Total	80.67%	81.75%	72.51%	84.18%	80.87%	84.91%
Patient Engagement After Inpatient Discharge 18–64 Years	89.29%	87.1%	81.88%	91.38%	88.24%	91.73%
Patient Engagement After Inpatient Discharge 65+	87.14%	87.74%	81.32%	89.83%	87.88%	91.37%
Patient Engagement After Inpatient Discharge Total	87.36%	87.59%	81.51%	90.27%	87.98%	91.48%
Receipt Discharge Information 18–64 Years	25%	16.13%	9.42%	13.79%	19.61%	18.8%
Receipt Discharge Information 65+	21.99%	18.55%	14.29%	20.68%	15.91%	26.26%
Receipt Discharge Information Total	22.3%	18%	12.65%	18.73%	16.94%	23.84%

Measure/Data Element	SNP PlanID 022	SNP PlanID 024	SNP PlanID 026	SNP PlanID 028	SNP PlanID 035	SNP PlanID 036
Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)						
History Of Falls	50.94%	52.05%	40.51%	44.64%	66.67%	50.3%2
Dementia	57.78%	59.74%	63.02%	59.25%	74.73%	63.33%
Chronic Kidney Disease	31.82%	31.59%	33.82%	33.83%	50%	38.46%
Total	**51.74%**	**51.03%**	**51.92%**	**50.06%**	**67.5%**	**53.58%**

Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com