Mercer

Government Human Services Consulting

Request for Proposal for External Quality Review Organizational Selection

2021-PRMP-RFP-002

The Government of Puerto Rico, Department of Health, Medicaid Program

February 4, 2022

Technical Response

Original

welcome to brighter

A business of Marsh McLennan

Contents

Section 1

Appendix 2: Technical Response and Evaluation Guide

Section A: Mandatory Requirements

The respondent must address all items detailed below and provide in sequence the information and documentation as required.

The evaluators will review the response to determine that the mandatory requirement items were addressed as required and mark each with a pass or fail. The evaluator shall detail the response page number, any reference information, and a pass/fail score for each item in the appropriate space below. For each item that is not addressed as required, the Proposal Evaluation Team could determine that the respondent did not comply with the RFP and reject the proposal. In addition to the mandatory requirement items, the Proposal Evaluation Team will review each response for compliance with all RFP requirements which may be reflected in the scoring of this section. This section is pass/fail – no points will be assigned for this Section.

Legal Name of Respondent: **Mercer Health & Benefits LLC**

Table 3: Mandatory Requirements

Response Page #	Reference	Mandatory Requirement Items	Pass/Fail
Page 3		The response must be delivered to PRMP no later than the Proposal Submission Due Date specified in Table 1: Schedule of Events.	
Page 3		The Technical Response and the Cost Proposal documentation must be packaged separately as required by the RFP.	
Page 3		The Technical Response must not contain cost or pricing information of any type.	
Page 3		The Technical Response must not contain any restrictions of the rights of PRMP or otherqualification of the response.	
Page 3		A respondent must not submit alternate responses as required by the RFP.	
Page 3		A respondent must not submit multiple responses in different forms, as principal or subcontractor.	
Pages 3, 4, 5	Appendix 1: Pages 4 and 5 Appendix A: Authorization to Sign Page 101 – 104	Provide the Statement of Certifications and Assurances (Appendix #1 of the RFP) duly completed and signed without exception.	
Pages 6, 7, 8, 9	Appendix 8: Pages 7, 8, and 9	Provide a statement that the respondent or any individual or subcontractor that will deliver the goodsor perform services under the contract resulting from this RFP, does not have any possible conflict of interest with any employee or official, of the Puerto Rico Department of Health, the Puerto Rico Health Insurance Administration (ASES) or any other Puerto Rico Government Agency	

Response Page #	Reference	Mandatory Requirement Items	Pass/Fail
Page 10		Provide written attestation that the respondent does attest, certify, warrant and help assure that the contractor shall not knowingly employ in the performance of the contract, employees who have been excluded from participation in the Medicare, Medicaid and or Children's Health Insurance Program (CHIP) Programs pursuant to Sections 1128 of the Social Security Act.	
Page 10		Provide written disclosure of lobbying activities, please refer to Appendix 6: Disclosure of Lobbying Activities of this RFP.	
Page 10		Provide the respondent's audited financial statements for the last three years. (If the respondent has less than three years in the business, provide the audited statements available).	
Pages 11, 12, 13, 14	Appendix 7: Pages 12, 13, and 14	Provide a sworn statement by a Notary Public to comply with Puerto Rico Law 2 of 2018 known as "Anticorruption Code for the New Puerto Rico" and any relevant details addressing whether the respondent is any of the following: (Please refer to Appendix 7: Sworn Statement on Fraud and Misappropriation and Debarement) a- Presently debarred, suspended, or excluded from participation by any other state or federal entity. b- Has been convicted or had a civil judgment rendered against the contracting party from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or grant under a public transaction, violation of state and federal anti-trust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.	
Page 15		Provide a written statement of whether there is any material, pending litigation against the respondent that the respondent should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the respondent financial condition. If such exists, list each separately explain the relevant details to what extent it would impair the respondent's performance in a contract pursuant to this RFP.	

Evaluator Name: _____

Evaluator Signature: _____

Date: _____

Table 3: Mandatory Requirements

The response must be delivered to PRMP no later than the Proposal Submission Due Date specified in Table 1: Schedule of Events.

Mercer Health & Benefits LLC (Mercer) acknowledges this requirement.

The Technical Response and the Cost Proposal documentation must be packaged separately as required by the RFP.

Mercer acknowledges this requirement and has packaged the Technical Response and Cost Proposal separately.

The Technical Response must not contain cost or pricing information of any type.

The Technical Response does not contain cost or pricing information of any type.

The Technical Response must not contain any restrictions of the rights of PRMP or other qualification of the response.

Mercer's Technical Response does not contain any restrictions of the rights of PRMP or other qualifications of the response.

A respondent must not submit alternate responses as required by the RFP.

Mercer has not submitted an alternate response.

A respondent must not submit multiple responses in different forms, as principal or subcontractor.

Mercer has submitted one response as principal vendor.

Provide the Statement of Certifications and Assurances (Appendix #1 of the RFP) duly completed and signed without exception.

Mercer has included a completed and signed Statement of Certifications and Assurances, Appendix 1, on the following page. Certificate authorizing Jessica Osbourne, Principal, as an authorized signor for Mercer are located in Appendix A of our response.

Appendix 1: Statement of Certifications and Assurances

The respondent must sign and complete the Statement of Certifications and Assurances below as required and it must be included in the Technical Response (as required by RFP Appendix 2: Technical Response and Evaluation Guide, Section A).

The respondent does, hereby, expressly affirm, declare, confirm, certify, and help assure all of the following:

1. The respondent will comply with all the provisions and requirements of the RFP.
2. The respondent will provide all services as defined in the scope of the RFP Appendix 10: Pro Forma Contract Draft.
3. The respondent, except as otherwise provided in the RFP, accepts and agrees to all terms and conditions set out in the RFP Appendix 10: Pro Forma Contract draft.
4. The respondent acknowledges and agrees that a contract resulting from the RFP shall incorporate, by reference, all proposal responses as a part of the contract.
5. To the knowledge of the undersigned, the information detailed within the response submitted to this RFP is accurate.
6. The response submitted to this RFP was independently prepared, without collusion, under penalty of perjury.
7. No amount shall be paid directly or indirectly to a Puerto Rico employee or official as wages, compensation, or gifts in exchanges for acting as an officer, agent, employee, subcontractor, or consultant to the respondent in connection with this RFP or any resulting contract.
8. Both the Technical Response and the Cost Proposal submitted in response to this RFP shall remain valid for at least 120 days subsequent to the date of the Cost Proposal opening and thereafter in accordance with any contract pursuant to the RFP.

By signing this Statement of Certifications and Assurances, below, the signatory also certifies legal authority to bind the proposing entity to the provisions of this RFP and any contract awarded pursuant to it. If the signatory is not the respondent (if an individual) or the respondent's company President of Chief Executive Officer, this document must attach evidence showing the individual's authority to bind the respondent.

DO NOT SIGN THIS DOCUMENT IF YOU ARE NOT LEGALLY AUTHORIZED TO SIGN FOR THE RESPONDENT

SIGNATURE: Jessica Osborne

PRINTED NAME & TITLE: Jessica Osborne, Principal

DATE: January 7, 2022

RESPONDENT LEGAL ENTITY NAME: Mercer Health & Benefits LLC

Provide a statement that the respondent or any individual or subcontractor that will deliver the goods or perform services under the contract resulting from this RFP, does not have any possible conflict of interest with any employee or official, of the Puerto Rico Department of Health, the Puerto Rico Health Insurance Administration (ASES) or any other Puerto Rico Government Agency

The completed, signed, and notarized Appendix 8, Absence of Conflict of Interest Certification, is provided on the following page.

Appendix 8: Absence of Conflict of Interest Certification

(Respondent Only)

PRMP and PRHIA requires that all contractors/subcontractors, when executing their professional services exhibit full loyalty toward PRMP and PRHIA, including having no adverse interests against it, as well as having no material adverse interests with other Puerto Rico Government entities.

Adverse interests include representing clients who have or may have interests that are contrary to PRMP and PRHIA or other Puerto Rico Government entities. This duty includes the continued obligation to disclose to PRMP and PRHIA any circumstances of its relations with clients and third persons that could influence the contractor or its subcontractor in a materially adverse way in the execution of its duties under the contract. Adverse interest also arise when, among others, the contractor/subcontractor must support on behalf of one client that which it has a duty to oppose on behalf of another client. Adverse interests also arise when so stated in standards of ethics applicable to the contractors / subcontractor profession, or Puerto Rico's laws and regulations.

It will also be considered a conflict of interest any instance where the contractor or any of its subcontractor, or any of their shareholders, members, employees, officers or its directors has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the contract would allow for private or personal benefit or for any other purpose that is consistent with the goals and objectives of the contract; or any instance where a contractor or any of its subcontractor, or any of their shareholders, members, employees, officers, or directors use their positions for purposes that are, or give the appearance of being for private gain for themselves or others, such as those with whom they have family, business, or other ties that are determined by PRMP or PRHIA in its sole discretion to be a conflict of interest.

By signing this certification, the respondent proposed subcontractor acknowledges and accepts that, if awarded a contract under this RFP:

a. It will not acquire any interest, direct or indirect, that would conflict in any material manner or degree with or have a material adverse effect on the performance of its services pursuant to this RFP.
b. No person having any such interest shall be employed and that it will notify PRMP and PRHIA if any conflict of interests arise after the execution of the contract.
c. It shall be the responsibility of the contractor/subcontractor to maintain independence and to establish necessary policies and procedures to assist the contractor and its subcontractor, if any, in determining if the actual individuals performing work under the contract have any impairment to their independence.
d. It shall take all necessary actions to eliminate threats to impartiality and independence included but not limited to reassigning, removing or terminating employees or subcontractors.
e. These requirements shall be in effect for the term of the contract including extensions, if any.

f. The duty to provide information about interests and conflicting relations is continuous and extends throughout the contract term.

Certification
I Jessica Osborne (full name), in my capacity of Principal

(position) from Mercer Health & Benefits LLC (organization name)

_____ after being authorized to represent Mercer Health & Benefits LLC (organization name) declare upon oath and certify that:
All the statements contained in this document have been read and fully understood by the undersigned, that I have been advised by my legal advisors and company's counsel on the obligations, acknowledgments and representations made in this certification and I accept the consequences of signing this certification; and
Check the ones that apply
__X__ That the respondent proposed subcontractor comply with the absence of conflict of interests
_____ A lack of independence situation exists, a detailed explanation of the same and the corresponding divestiture action plan is attached to this certification
_____ A conflict of interest does not exist, a detailed explanation of the same and a conflict avoidance plan to address the conflict of interest is attached to this certification.
_____ A suspected or potential conflict of interest exits or is expected to occur during the term of the contract, and additional information is attached along with a conflict avoidance plan to address the possible conflict of interest.
And in Witness Thereof, I swear and sign this affidavit on January 7 of 2022

Jessica Osborne
Signature of Declarant

Jessica Osborne
Name of Declarant
Position Principal
Company name Mercer Health & Benefits LLC

Sworn and subscribed before me by Jessica M. Osborne whose personal circumstances have been previously stated, and whom I gave faith to know personally/have identified by means of VA Driver's License.

In City of Alexandria, January 10 of 2022
(location)

Notary Public

ROXANA X MENDEZ
Notary Public
Commonwealth of Virginia
Registration No. 7216818
My Commission Expires Jun 30, 2024

Place seal here

Provide written attestation that the respondent does attest, certify, warrant and help assure that the contractor shall not knowingly employ in the performance of the contract, employees who have been excluded from participation in the Medicare, Medicaid and or Children's Health Insurance Program (CHIP) Programs pursuant to Sections 1128 of the Social Security Act.

Mercer attests, certifies, and warrants that we shall not knowingly employ in the performance of the contract employees who have been excluded from participation in the Medicare, Medicaid, and/or Children's Health Insurance Program (CHIP) Programs pursuant to Sections 1128 of the Social Security Act.

Provide written disclosure of lobbying activities, please refer to Appendix 6: Disclosure of Lobbying Activities of this RFP.

Mercer Health & Benefits LLC does not have any lobbying activities to disclose.

Provide the respondent's audited financial statements for the last three years. (If the respondent has less than three years in the business, provide the audited statements available).

Most Recent Audited Financial Statement

Mercer is a wholly owned subsidiary of Marsh McLennan. Audited financial information specific to Mercer and its health business is reported within the consolidated statements of Marsh McLennan. A separate financial audit is not performed and reported on Mercer LLC (global corporation), Mercer (US) Inc., or Mercer Health & Benefits LLC individually.

The 2020 Marsh McLennan Annual Report (https://irnews.mmc.com/static-files/5935c58e-864f-4fd7-a8bf-6a7569bc51c5) is available through the link provided and included as a separate attachment to our response. The report includes the audit opinion, balance sheet, statements of income, retained earnings, cash flows, and the notes to the financial statements for the last three years (2018, 2019, and 2020).

Five-Year Revenue History

To demonstrate that Mercer and Marsh McLennan possess the necessary financial strength to undertake any task orders that may be issued under this Request for Proposal (RFP), the following table provides a summary from the annual report of revenue for Mercer and Marsh McLennan for the past five years.

Mercer and Marsh McLennan worldwide five-year revenue history (in US$ millions)					
Company	**2020**	**2019**	**2018**	**2017**	**2016**
Mercer	$4,928	$5,021	$4,732	$4,528	$4,323
Marsh McLennan	$17,224	$16,652	$14,950	$14,024	$13,211

Provide a sworn statement by a Notary Public to comply with Puerto Rico Law 2 of 2018 known as "Anticorruption Code for the New Puerto Rico" and any relevant details addressing whether the respondent is any of the following: (Please refer to Appendix 7: Sworn Statement on Fraud and Misappropriation and Debarment) a- Presently debarred, suspended, or excluded from participation by any other state or federal entity. b- Has been convicted or had a civil judgment rendered against the contracting party from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or grant under a public transaction, violation of state and federal anti-trust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property.

Mercer has included a completed, signed, and notarized Sworn Statement on Fraud and Misappropriation and Debarment, Appendix 7, on the following page.

Appendix 7: Sworn Statement on Fraud and Misappropriation and Debarment (Respondent Only) As Required by Puerto Rico Law #2 of January 4th, 2018

Sworn Statement

I (full name) Jessica Osborne of legal age, (marital status) Single, (profession) Principal/Consultant and resident of (city and state) Alexandria, Virginia, under the most solemn oath,

1. That my name and other personal circumstances are as previously described.

2. That the Board of Directors has been informed of the content of this sworn statement and that it has authorized me by means of a resolution of the Board of Directors to subscribe this sworn statement.

3. That I am the President of the company (organization name) _____, which is duly organized and or authorized to do business pursuant to the Laws and regulations of the Government of Puerto Rico. Or in the alternative: That I am in the Principal (position) of (entity Name) Mercer Health & Benefits LLC and because the President is not available to notarize this document, I have been authorized according to paragraph 2, for signing this sworn statement.

4. That I am legally authorized by the company to sign this sworn statement.

5. That in the best of my knowledge and after diligent investigation, the company, its subsidiary companies, affiliates, and or headquarters, and their respective shareholders, directors, associates, officers, executives, principals and/or employees, and/or business associates, have not been convicted, no probable cause has been found for their arrest, nor they are under investigation in any legislative, judicial or administrative procedure, whether in or out the jurisdiction of Puerto Rico, for reasons of any conduct that may be held to constitute fraud, embezzlement or illegal appropriation of public funds, according to the provisions of Act 2 of January 4, 2018 known as the "Anticorruption code for the New Puerto Rico", or any another legal provision that penalizes crimes against the treasury and the public confidence, and neither have I, the declarant, been investigated, arrested, convicted, declared guilty nor sentenced for the conducts previously mentioned. Or In the alternative: in the case of having knowledge that any of the persons identified in the above-mentioned positions or categories have been on are being investigated, arrested, declared guilty, convicted or sentenced for such conduct and/or criminal offences referred to in the preceding paragraph, a statement regarding this fact shall form part of this sworn declaration. The statement must be included in an additional sheet describing positions, full names, charges, description of the offence or offences for which they have been or are being investigated, convicted, or sentenced, including current processes status.

6. I give faith that I have personal knowledge, as does the company, its subsidiary, companies, affiliates, and or headquarters, and/or their respective shareholders, directors, associates, officers, executives, principals, and or employees, that the crimes referred to in these provisions include, but are not limited to:

a. Aggravated illegal appropriation, in all of its modalities;
b. Extortion;
c. Fraud in constructions;
d. Fraud in the execution of construction work;
e. Fraud in the delivery of things;
f. Undue intervention in the contracting processes of auctions or in the operations of the government;
g. Bribery, in all its modalities;
h. Aggravated bribe;
i. Offering a bribe;
j. Undue influence;
k. Crimes against public funds;
l. Preparation of false documents;
m. Forgery of documents;
n. Possession and transfer of false documents; and
o. Crimes under the laws of the United States and its territories and state jurisdiction of the United States, whose elements are equivalent to those of the crimes aforementioned.

7. That I have been advised by my legal advisors and company's counsels on the obligations imposed by ACT 2 – 2018, and other applicable laws, and I acknowledge and accept the consequences of signing this sworn statement.

8. That I certify that I as well as the company, know of our continuous duty to report on any investigation, accusation or conviction against the company, its subsidiary companies, affiliates and/or headquarters, and/or their respective shareholders, directors, associates, officers, executives, principals and/or employees, related to the crimes and undue conducts listed in clause 5 & 6.

9. I certify that neither, the declarant nor the company, its subsidiary companies, affiliates and/or headquarters, and/or their respective shareholders, directors, associates, officers, executives, principals and/or employees, to the best of my knowledge or according to what has been informed to me, has been or is presently debarred, suspended, or excluded from participation by any other state or federal entity.

10. I certify that neither, the declarant nor the company, its subsidiary companies, affiliates and/or headquarters, and/or their respective shareholders, directors, associates, officers, executives, principals and/or employees, to the best of my knowledge or according to what has been informed to me, have incurred nor will we incur in conducts that violate the law, anti-trust federal and state regulations and guidelines, such as agreeing with another company and/or company proponent to set fixed prices, submit proposals or take another action for the purpose of impeding, restricting or limiting free competition; or that may have an adverse or negative impact on the services to be offered to the population.

11. That the above declared is the truth and nothing but the truth

and in Witness Thereof, I swear and sign this affidavit on 10th of January of 2021

Jessica Osborne

Signature of Declarant

Name of Declarant Jessica Osborne

Position Principal

Company name Mercer Health & Benefits LLC

Sworn and subscribed before me by Jessica M. Osborne whose personal circumstances have been previously stated, and whom I gave faith to know personally/have identified by means of VA Drivers License.

In City of Alexandria, January 10, of 2022 RM (location)

Reminder

Notary Public

ROXANA X MENDEZ
Notary Public
Commonwealth of Virginia
Registration No. 7216818
My Commission Expires Jun 30, 2024

Place seal here

Provide a written statement of whether there is any material, pending litigation against the respondent that the respondent should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the respondent financial condition. If such exists, list each separately explain the relevant details to what extent it would impair the respondent's performance in a contract pursuant to this RFP.

From time to time, in the ordinary course of business — similar to other firms of our size — Mercer is involved with litigation and other legal proceedings, investigations, and inquiries, some of which are conducted industry-wide, and none of which would be expected to adversely impact our ability to perform services for you. Details on certain outstanding legal proceedings pertaining to Mercer and its affiliates are disclosed in the public Securities and Exchange Commission filings of Marsh McLennan, Mercer's ultimate parent company.

Section 2

Section B: General Qualification and Experience

A Proposal Evaluation Team member will independently evaluate and score the response to each item. Each evaluator will use the following whole numbers for scoring each item (using an example 0-3 point scale):

0 points – Poor

1 point – Fair

2 points – Satisfactory

3 points – Excellent

Respondent Legal Name: **Mercer Health & Benefits LLC**

Table 4: General Qualifications and Experience

Response Page Number	Reference	General Qualifications and Experience	Points
Page 19		Detail the name, email address, mailing address, telephone number, and facsimile number of the person Puerto Rico needs to contact regarding the response.	
Pages 19 and 20		Describe the respondent's form of business (individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company, and business location).	
Page 20		Detail the number of years the respondent has been in business.	
Page 20		Briefly describe how long the respondent has been providing the goods or services required in this RFP.	
Pages 20 and 21		Describe the respondent's number of employees, client base, and location of offices.	
Page 21		Provide a written statement of whether in the last 10 years, the respondent has filed any bankruptcy or insolvency proceeding whether voluntary or involuntary or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If necessary, provide explanation.	
Pages 22 and 23		Provide a brief descriptive statement detailing evidence of the respondent's ability to deliver the goods and services sought under this RFP.	
Pages 24 and 25	Organization Chart: Page 25	Provide a narrative description of the proposed project team, its members and organizational structure along with an organizational chart identifying key people who will be assigned to deliver the goods or services required by the RFP.	

Response Page Number	Reference	General Qualifications and Experience	Points
Page 25 through Page 51	Personnel Roster: Pages 25 and 26 Resumes: Pages 27 – 51	Provide a personnel roster listing the names of key people who the respondent will assign to meet the respondent's requirements under this RFP along with the estimated number of hours that each individual devoted to that performance. Follow the personnel roster with a resume for each of the individuals listed. Each resume should be limited to three (3) pages.	
Pages 51 and 52	Subcontractor Letter: Page 52	Provide a statement of whether the respondent intends to use subcontractors to meet the respondent's requirement of any contract awarded pursuant to this RFP. Please list the following: Name of the subcontractor A description of the scope of each subcontractor involved A letter from each subcontractor assenting that has been proposed as subcontract.	
Page 53	Appendix 5 Reference Questionnaires are included as an inclusion in the Original binder of our response	Provide three (3) customer references from individuals or entities (who are not current or former officials of the Government of Puerto Rico) for projects similar to the services sought under this RFP and which represent largest accounts serviced by the respondent. All references must be provided using the standard reference questionnaire included as Appendix 5: Reference Questionnaire in the RFP. Each reference questionnaire must be completed and signed. Puerto Rico will not review more than the number of references required in this RFP (3).	
Pages 53 and 54		Provide documentation of the respondent's commitment to diversity, example: *Provide a description of the respondent's existing internal programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities including, women, veterans, disabled veterans, Latino Community, Asian, African American, LGBTQ Community, etc. This may include contractors or subcontractors.* Note: This section is not a prerequisite and is not required to be able to receive a maximum evaluation score. However, if complied with in satisfactory form, there will be a bonus of two (2) points.	Bonus
Total Points for Section B Maximum possible section score = 33 points Maximum possible section bonus score = 2 points			

The total maximum points possible for this section is 33 section points plus a maximum of two (2) bonus points. This section is weighted 20% of the total possible response score of 100 response points. An example calculation of the total response points awarded based on a perfect section score including bonus points is:

$$\frac{\text{35 section points}}{\text{33 section points}} \times 20\% \times 100 = 21.21 \text{ response points}$$

Evaluator Name: _____

Evaluator Signature:_____

Date:_____

Table 4: General Qualifications and Experience

Detail the name, email address, mailing address, telephone number, and facsimile number of the person Puerto Rico needs to contact regarding the response.

Jessica Osborne, Principal, will serve as the primary point of contact for Puerto Rico regarding this response. Jessica's contact information is listed below.

Primary Contact Information	
Business Name:	Mercer Health & Benefits LLC
Contact Person's Name and Title:	Jessica Osborne, Principal
Mailing Address:	1050 Connecticut Ave, NW, Suite 700 Washington, DC 20036
Direct Telephone Number:	+1 941 718 6016
Facsimile Number:	+1 202 296 0909
Email Address:	jessica.m.osborne@mercer.com

Describe the respondent's form of business (individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company, and business location).

Marsh McLennan

Marsh McLennan, a publicly traded organization (NYSE: MMC), is the world's leading professional services firm in the areas of risk, strategy, and people. Since its founding in 1871, our 76,000+ colleagues advise clients in over 130 countries with a common purpose: to make a meaningful difference for our clients, our colleagues, and the communities in which we live and work. Marsh McLennan helps clients through four market-leading firms: Marsh, Guy Carpenter, **Mercer**, and Oliver Wyman. Marsh McLennan's corporate headquarters are in New York, NY.

Mercer

Mercer is a wholly owned subsidiary of Marsh McLennan with approximately 25,000 employees operating in over 130 countries worldwide. Mercer (US) Inc. is the US operating company within Mercer LLC. In 2005, Mercer (US) Inc. established a separate health and benefits entity, Mercer Health & Benefits LLC, which offers a wide range of health and benefits consulting to public and private entities. Mercer Health & Benefits LLC is now one of the largest healthcare and benefits consulting and brokerage services companies in the world, with 66 US-based offices.

The legal entity responsible for this contract is Mercer Health & Benefits LLC and is a limited liability company.

Mercer Government Human Services Consulting

Mercer has been providing specialized government-focused consulting since 1985, and in 1992 Mercer officially designated the Government Human Services Consulting (GHSC) group as a specialty consulting practice within the Mercer organization. Since then, Mercer GHSC

has continued to grow by providing comprehensive consulting services in all areas of Medicaid, Children's Health Insurance Program (CHIP), and human services program management, with significant experience in External Quality Review (EQR). Our team now includes over 400 dedicated consultants with a variety of backgrounds. Mercer GHSC employees are based in Atlanta, Minneapolis, Phoenix, and Washington, DC — as well as staff who work remotely across the country — to serve our clients nationwide.

Detail the number of years the respondent has been in business.

Mercer started in the United States in 1937 as the employee benefits department of Marsh McLennan. The Mercer Government specialty practice, which will be responsible for the work under this contract, has been in operation for more than **36 years** and provides comprehensive consulting services in all areas of Medicaid, CHIP, human services program management, and EQR, primarily to state clients. Since its founding, GHSC has provided policy, financial, and related services in **45 states and US territories**.

Briefly describe how long the respondent has been providing the goods or services required in this RFP.

We have been providing EQR and EQR-like services for over 19 years to several states, including Arizona, Connecticut, Delaware, the District of Columbia, Kansas, Louisiana, Minnesota, New Mexico, North Carolina, Pennsylvania, and Virginia. In addition, Mercer offers the invaluable experience of having assisted Puerto Rico as a trusted advisor over the last 11 years, allowing us to bring a deep understanding of your healthcare delivery system, reimbursement structure, service provider network, and capacity.

Describe the respondent's number of employees, client base, and location of offices.

The more than 400 employees of Mercer Government work almost exclusively with state and territory Medicaid programs and other government agencies responsible for providing care to Medicaid populations. Our teams come from diverse backgrounds and offer a rich array of experience.

GHSC provides expert consulting services in all areas of publicly funded health and human services programs, including acute care, behavioral health (BH), pharmacy, and long-term services and supports (LTSS). Our work has spanned many populations, such as children and youth, including those with special healthcare needs; adults; expansion populations; older adults; individuals with disabilities; individuals dually eligible for Medicaid and Medicare; individuals with intellectual and/or developmental disabilities (I/DD); individuals with HIV/AIDS; and individuals with serious BH conditions.

Mercer's government practice has offices in Atlanta, Georgia; Minneapolis, Minnesota; Phoenix, Arizona; and Washington, DC, but our staff work all over the United States from home offices in addition to the traditional workspace. Our proposed lead for this project, Lois Heffernan, MBA, BSN, RN, works from Jacksonville, Florida and our client leader Jessica Osborne works from Alexandria, Virginia. In addition, Mercer is investigating the practicality of adding an office in San Juan.

Legal Entity	Mercer Health and Benefits LLC
Professional Services Managed	3560 Lenox Road, Suite 2400, Atlanta, GA 85016
	333 South 7th Street, Suite 1400, Minneapolis, MN 55402
	2325 East Camelback Road, Suite 600, Phoenix, AZ 85016
	1050 Connecticut Avenue NW, Suite 700, Washington, DC 20036

Provide a written statement of whether in the last 10 years, the respondent has filed any bankruptcy or insolvency proceeding whether voluntary or involuntary or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If necessary, provide explanation.

Neither Mercer nor its parent company, Marsh McLennan, have ever declared for insolvency, filed for reorganization, or filed for bankruptcy.

Provide a brief descriptive statement detailing evidence of the respondent's ability to deliver the goods and services sought under this RFP.

Mercer can meet the qualification as an External Quality Review Organization (EQRO) with capabilities that extend beyond the standard competence and independence requirements outlined in 42 CFR 438.354 and Puerto Rico-specific managed care organization (MCO) contract requirements. We can provide Medicaid program design, policy guidance, and quality improvement support not typical of other EQROs. Throughout our RFP response, we describe and highlight our breadth and depth of experience in Puerto Rico Medicaid and demonstrate how Mercer offers the competency and expertise to be your EQRO. We are eager and excited about the opportunity to support the Puerto Rico Government Health Plan with new perspectives and lessons learned from other state Medicaid programs.

Members of the Puerto Rico EQR team have over 90 years of combined managed care operations experience; we have been "in the trenches" and have intimate knowledge and understanding of all managed care functions. Our knowledge of MCO operations allows us to quickly identify activities and processes that are inefficient, ineffective, or inconsistent with the Puerto Rico Medicaid Program's (PRMP's) desired goals, objectives, and outcomes so we can develop strong and **enforceable** recommendations for improvements to close gaps.

Mercer offers an interdisciplinary team of consultants with broad knowledge and experience in Medicaid and CHIP waiver design, rules for Medicaid managed care, and understanding of how states and managed care plans design high-quality programs within these expectations. This team complements the EQR consultants to address issues of federal compliance and opportunities to leverage EQR to inform and drive state policy and ensures the EQR team stays up to date on the federal landscape as the federal rules for Medicaid managed care and quality oversight continue to evolve. Specifically, Mercer has conducted in-depth studies of Network Adequacy and Program Integrity and has performed multiple readiness reviews in Puerto Rico. Mercer supported PRMP during a formal audit by the Centers for Medicare & Medicaid Services (CMS) Medicaid Integrity Group and negotiated and managed corrective action plans (CAPs) with the MCOs.

We have experience providing comprehensive compliance support to ensure compliance with Medicaid and CHIP Managed Care Final Rule (Managed Care Final Rule). We have also provided technical support on Medicaid claims rules and regulations for BH and substance use disorder (SUD) services provided to Medicaid-eligible populations, including a recent Mental Health Parity review for PRMP. Our team has provided timely and comprehensive responses to ad hoc questions, Affordable Care Act expansion populations, 1115 waivers, 1915(c) waivers, and summaries of other state Medicaid initiatives.

Mercer's expertise as a full-service consulting firm highlights the sophistication of our knowledge related to Medicaid data and data systems. Our knowledge includes specialized expertise in the operation of state Medicaid Management Information Systems (MMIS), the integration of vendor systems (for example, managed care, dental, pharmacy benefit managers, and transportation), and the impact delegated relationships, benefit coordination, and third-party liability have on the capture and control of critical claims and encounter

information. **This end-to-end knowledge is critical to performing key EQR activities, including conducting Information Systems Capabilities Assessments (ISCAs), performance measure validation (PMV), and encounter data validation.** This experience can be leveraged in fee-for-service (FFS) delivery models as well.

As an experienced EQRO, Mercer has extensive knowledge and experience in the application of quality assessment and performance improvement (QAPI) methods. We use the CMS' Quality Framework, which incorporates QAPI activities, and we recognize the primacy of the Quality Management Strategy (QMS) in establishing the structure through which these QAPI activities occur.

MERCER IN ACTION

Our consultants have conducted EQR activities in Delaware that directly impact the lives of Medicaid recipients. We have helped to improve information exchange beyond the Division of Medicaid & Medical Assistance (DMMA), the State Medicaid Agency, and reduced fragmentation through conducting performance improvement projects (PIPs), assisting in the development and refinement of the State's QMS, and engaging MCOs as key collaborators with other State organizations. These collaborative efforts have led to more coordinated services for foster children, enhanced service arrays, and improved service coordination for individuals with persistent mental illness, and ensured continuity of services when new MCOs entered the market.

Our efforts have resulted in program innovations including opioid prescribing practices, BH integration, development of value-based performance measurement approaches, alternative payment arrangements, quality and cost benchmark efforts, and public reporting and transparency. All of which are designed to meet Delaware's QMS goals and provide the best care to Medicaid recipients.

Mercer brings years of research design, analysis, and reporting experience to benefit of our clients. Mercer's experience ranges from sampling and tool development, including data mining algorithms and medical record abstraction databases, to performing statistical analysis, such as descriptive, inferential, and multivariate statistics. Our expertise includes clinical and non-clinical areas and covers selecting, calculating, and validating Healthcare Effectiveness Data and Information Set (HEDIS®) and non-HEDIS outcomes and performance measures (PMs); performing medical record abstraction; conducting geospatial mapping to detect utilization and referral patterns; analyzing the impact of pay-for-performance and other value-based payment (VBP) strategies, and conducting a host of other quality of care and service studies.

Our experience also includes the collection of qualitative data for analysis. This type of research methodology allows us to explore data not amenable to quantification, answering questions about members' perceptions, and why certain behaviors persist. We use qualitative methods to uncover and understand what lies behind the data, with findings used to clarify and illustrate quantitative findings, build survey instruments, guide practices, and support policy development. This expertise allow us to include data collection methods such as case studies, focus groups, stakeholder groups, and interviews. Our EQR team includes doctoral-level biostatisticians, healthcare researchers, licensed clinicians and pharmacists, healthcare data analysts, and informatics specialists with expertise in all aspects of research design, data validation, measure calculation, statistical analysis, and report writing.

Provide a narrative description of the proposed project team, its members and organizational structure along with an organizational chart identifying key people who will be assigned to deliver the goods or services required by the RFP.

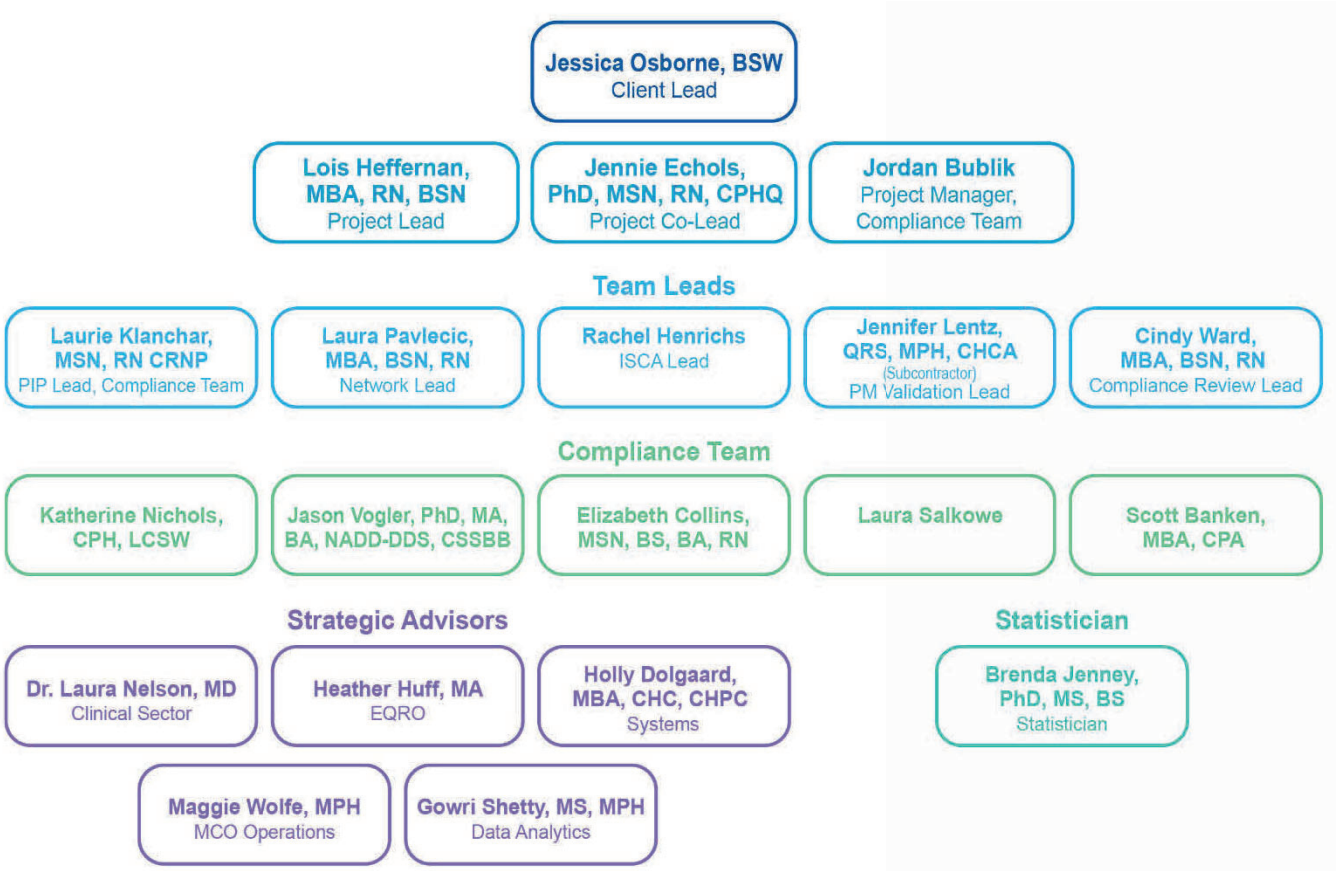
Members of the proposed EQR core team for PRMP have worked with some of the largest and most complex Medicaid programs in the country, including California, Florida, Massachusetts, New Jersey, Ohio, and Pennsylvania. Our understanding of healthcare delivery models stretches beyond managed care and includes a wealth of experience with broader delivery system elements, including accountable care organizations (ACOs), FFS, enhanced primary care models, medical and health home programs, prepaid ambulatory health plans, administrative services-only models, and dual Medicare/Medicaid integration models.

Puerto Rico Government Health Plan Experience

Mercer has a long-standing relationship with Puerto Rico, having worked with the Administración de Seguros de Salud (ASES) and Medicaid on a variety of projects over the past 11 years. A Mercer team supported MCO readiness reviews in 2010, 2015, and 2018. In 2021, Mercer completed a Program Integrity Audit of MCO activities, a network adequacy evaluation and certification for each procurement, a comprehensive network adequacy study to support the upcoming MCO procurement and a Mental Health Parity compliance review. Our experience with Medicaid includes providing assistance with early expansion of Medicaid Eligibility, monitoring federal rules, and supporting a compliant State Plan through the development of multiple State Plan Amendments, which we helped Puerto Rico successfully negotiate with CMS. We have provided support and training to all levels of agency staff and across multiple administrations. Mercer has a deep investment in PRMP's success and the future of the Medicaid program. While the EQR-specific team members are largely new to the project, the client leader, Jessica Osborne, has worked with Puerto Rico since 2010 and several key team members and advisors have been involved since 2012.

The core EQR team members will be supported by consultants who have worked with PRMP on other Medicaid projects and possess a unique breadth and depth of understanding of the PRMP. All of the proposed EQR team are knowledgeable of national Medicaid trends in design and improvement initiatives and managed care delivery models. This allows us to deliver the greatest value in assessing, designing, and implementing EQR activities to address your most pressing issues and concerns of today while helping you build your vision for the PRMP of tomorrow.

Lois Heffernan, MBA, BSN, RN will lead our proposed team. Lois will be assisted by co-lead Jennie Echols, PhD, MSN, RN, CPHQ, and project manager Jordan Bublik. The management team will confirm expectations, communicate with PRMP, and ensure timely work of the highest quality from the larger team. Each area of the EQR scope of work is assigned a lead subject matter expert (SME) who will be supported by a larger support team as stated in the following organization chart. The EQR team will have the support of key strategic advisors who available bring additional subject matter expertise or resources when needed. The strategic advisor team represents each department within Mercer and offers a connection to the breadth of our entire company's experience.



Provide a personnel roster listing the names of key people who the respondent will assign to meet the respondent's requirements under this RFP along with the estimated number of hours that each individual devoted to that performance. Follow the personnel roster with a resume for each of the individuals listed. Each resume should be limited to three (3) pages.

The following key personnel will be assigned as the primary team for the Puerto Rico work. Additional expertise may be needed to address a specific issue; in those cases, using our strategic advisors, we would identify individuals from the larger Mercer team to support the project. The following hours represent estimated hours worked over the potential five-year life of the contract.

Key Personnel	Role	Projected Hours
Jessica Osborne, BSW	Client Leader	200
Lois Heffernan, MBA, RN, BSN	Project Lead	3,000
Jennie Echols, PhD, MSN, RN, CPHQ	Project Co-Lead	1,100
Jordan Bublik	Project Manager, Compliance Team	2,800
Laurie Klanchar, MSN, RN, CRNP	PIP Lead, Compliance Team	1,650
Laura Pavlecic, MBA, BSN, RN	Network Lead	1,400

Key Personnel	Role	Projected Hours
Rachel Henrichs	ISCA Lead	2,400
Jennifer Lentz, QRS, MPH, CHCA	PMV Lead	910
Cindy Ward, MBA, BSN, RN	Compliance Review Lead	750
Katherine Nichols, CPH, LCSW	Compliance Team	900
Jason Vogler, PhD, MA, BA, NADD-DDS, CSSBB	Compliance Team	650
Elizabeth Collins, MSN, BS, BA, RN	Compliance Team	950
Laura Salkowe	Compliance Team	950
Scott Banken, MBA, CPA	Compliance Team	200
Brenda Jenney, PhD, MS, BS	Statistician	200
Dr. Laura K. Nelson, MD	Strategic Advisor — Clinical Sector	15
Heather Huff, MA	Strategic Advisor — EQRO	50
Holly Dolgaard, MBA, CHC, CHPC	Strategic Advisor — Systems	15
Maggie Wolfe, MPH	Strategic Advisor — MCO Operations	15
Gowri Shetty, MS, MPH	Strategic Advisor — Data Analytics	15

Resumes for key personnel are located on the following pages.

Jessica Osborne, BSW, Principal

Summary of Experience

Jessica Osborne is a principal in Mercer's Government Human Services Consulting group in the Washington, DC office. Jessica is a Medicaid operations expert with 20 years of experience. She is the client leader for Puerto Rico and will serve as a strategic advisor as needed.

Education

- 2000 Bachelor of Arts in Social Work, University of South Florida

Years of Experience

- 13 Mercer Experience, 20 Career Experience

Relevant Experience

- **Readiness Reviews**
  - 2021–present State of Ohio, Department of Medicaid
    - Develop readiness review standards for the implementation of new Medicaid managed care plans with a focus on member and provider services, including the development of standards for desk review and on-site operations reviews to occur prior to go-live.
  - 2010–present Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico
    - Lead combined client staff and Mercer teams through comprehensive readiness reviews for five MCOs, including desk reviews and on-site operations reviews across three separate MCO procurements.
    - Organize and train client and Mercer review teams, lead the development of desk review guides and on-site review tools, facilitate on-site review sessions, develop readiness review report CAPs, and manage all follow-up activities.
    - Develop and implement a readiness review tool with all contractually-required elements, including tools for desk review and on-site operations review.
    - Lead review and report drafting for a new Enrollment Counselor.
- **Care Coordination & Case Management Strategies**
  - State of New Mexico, Human Services Department
    - Design and conduct a care coordination audit aimed at establishing strengths and weaknesses in the implementation of the Centennial Care care coordination requirements.
    - Develop tools, conduct file reviews and interviews with MCOs, draft report on findings, and develop CAPs for MCOs.

Lois Heffernan, MBA, RN, BSN, Principal

Summary of Experience

Lois has conducted and managed both mandatory and optional EQR activities for a number of state Medicaid agencies. Lois has conducted and managed EQR activities for state Medicaid programs for seven years and previously worked in quality oversight at MCOs. Lois brings experience in compliance assessment, quality improvement processes, performance measurement, and data analysis to provide actionable recommendations for improvement in processes and outcomes. Her experience includes seven years in EQR and eight years in quality roles in Medicaid/Medicare MCOs.

Education

- 1987 Master of Business Administration, Ohio State University
- 1983 Bachelor of Science in Nursing, Ohio State University

Certifications and Licenses

- 2017 Registered Professional Nurse, Florida Board of Nursing
- 2004 Paralegal Certificate, Capital University
- 1983 Registered Professional Nurse, Ohio Board of Nursing

Years of Experience

- <1 Mercer Experience, 31 Career Experience

Relevant Experience

- **External Quality Review**
  - 2017–2022 Florida Healthy Kids
    - Implement and manage all EQR activities for the Florida Healthy Kids program (Medicaid/CHIP), including managing team members to ensure timely and accurate completion of EQR deliverables.
    - Act as the primary contact with Florida Healthy Kids Corporation to facilitate compliance with contract requirements.
    - Conduct annual regulatory and contract compliance assessments of health and dental managed care plans, including development of review tools, desk review of plan documentation, on-site (or virtual) reviews, and completion of reports of compliance, including recommendations for CAPs.
    - Conduct annual clinical and non-clinical PIP validation, including quarterly assessments of Plan-Do-Study-Act rapid-cycle performance improvement activity.
    - Direct completion of quarterly claims/encounter validation.
    - Conduct annual PMV.
    - Direct completion of annual medical and dental network adequacy assessments.
    - Develop annual EQR Technical Reports assessing and comparing MCO strengths and weaknesses related to quality, timeliness, and access to healthcare services.
    - Develop and deliver informal and formal technical assistance (TA) for MCOs, including comprehensive presentations and supportive materials, related to mandatory and optional EQR activities.
    - Assist in proposal development and new contract implementation.

    - Lead and manage staff training on compliance and quality activities.
  - 2017 Commonwealth of Massachusetts, MassHealth
    - Conduct triennial regulatory and contractual compliance reviews for three Medicaid managed care programs: Medicaid MCOs; Senior Care Options (SCOs); and Integrated Care Organizations.
    - Develop assessment tools, complete desk review, and conduct on-site reviews, including interviews of key staff, to assess compliance of 10 managed care plans' compliance with federal and Commonwealth regulations and contract requirements.
  - 2015 Commonwealth of Virginia, Department of Medical Assistance Services
    - Conduct triennial regulatory and contractual compliance reviews for Medicaid MCOs.
    - Develop assessment tools, complete desk review, and conduct on-site reviews, including interviews of key staff, to assess compliance of MCOs' compliance with federal and Commonwealth regulations and contract requirements.
    - Develop comprehensive reports of compliance, including identification of areas of deficiency and CAPs.
  - 2013 State of Ohio, Department of Medicaid
    - Conduct triennial regulatory and contractual compliance reviews for Medicaid and Duals Demonstration MCOs.
    - Develop assessment tools, complete desk review, and conduct on-site reviews, including interviews of key staff, to assess compliance of MCOs' compliance with federal and State regulations and contract requirements.
    - Develop comprehensive reports of compliance, including identification of areas of deficiency and CAPs.
    - Conduct annual clinical and nonclinical PIP validation.
    - Participate in the facilitation of collaborative PIPs.
    - Contribute to the development of annual EQR Technical Reports assessing and comparing MCO strengths and weaknesses related to quality, timeliness, and access to healthcare services.
- **Program Evaluation**
  - 2015 Centers for Medicare & Medicaid Services
    - Assess performance of various states' 1915(c) home- and community-based services (HCBS) waiver programs.

Jennie Echols, PhD, MSN, RN, CPHQ, Principal

Summary of Experience

Jennie manages and provides expertise for projects involving Medicaid MCO reviews, clinical program development, implementation, and program evaluation. She brings experience with the implementation of strategies to improve clinical outcomes, member engagement, assessment, and cost efficiency through care management, health informatics, technology, and quality improvement processes. Jennie was previously Director of Clinical Services and Innovation for a national healthcare management company, where she implemented and directed population health management programs for government programs.

Education

- Doctor of Philosophy in Nursing, University of Alabama at Birmingham
- Master of Nursing Administration and Psychiatric Nursing, University of Alabama
- Bachelor of Science in Nursing, University of Alabama at Birmingham

Certifications and Licenses

- Certified Professional in Healthcare Quality, National Association of Healthcare Quality
- Registered Professional Nurse — e-NLC, Georgia Board of Nursing

Years of Experience

- 8 Mercer Experience, 25+ Career Experience

Relevant Experience

- **External Quality Review**
  - 2006–2012 State of Connecticut Department of Social Services
    - Develop EQRO requests for information, survey tools, and reporting templates.
    - Review PIPs for each MCO with annual reporting.
    - Develop contract requirements for new Administrative Services Organization (ASO).
    - Conduct readiness review of new ASO.
- **Quality & Performance Measurement**
  - 2019–present Commonwealth of Virginia, Department of Medical Assistance Services
    - Provide TA to develop clinical efficiency measure technical specifications.
    - Lead the Mercer team and provide expertise on data and coding logic.
- **Program Evaluation**
  - 2019–2020 State of New Mexico, Human Services Department
    - Develop driver diagrams for structuring the State's 1115 waiver evaluation plan.
    - Lead technical development of quality measures with denominator and numerator definitions.
  - 2019 State of Delaware, Department of Health and Social Services
    - Conduct research and a State scan of benefits and outcomes associated with the implementation of coverage of acupuncture and chiropractor benefits.
    - Develop plan to evaluate pilot based on logic model elements.
    - Facilitate workgroup calls with Medicaid and State employee stakeholders.

Jordan Bublik, Associate Clinical/Program Consultant

Summary of Experience

Jordan has over ten years of healthcare experience and currently provides consulting services to Mercer's state Medicaid clients with managed care design, implementation, and quality. Jordan currently serves as a project manager and consultant on Medicaid procurements for Ohio and Puerto Rico. She also supports Delaware with benchmarking healthcare quality measures. Prior to joining Mercer, Jordan most recently worked as a Senior Analytics Coordinator in Data Science and Advanced Analytics division specializing in Medicare quality reporting and dashboarding, patient safety reporting and dashboarding, and project management.

Education

- 2012 Bachelor of Science in Cells, Genetics, & Developmental Biology and Psychology, Arizona State University
- 2014 Masters of Science in the Science of Health Care Delivery, Arizona State University

Certifications and Licenses

- 2021 Lean Six Sigma Green Belt, Management and Strategy Institute
- 2021 Lean Project Management, Management and Strategy Institute
- 2021 Executive Management, Management and Strategy Institute
- 2021 Associate in Project Management, Management and Strategy Institute

Years of Experience

- 1 Mercer Experience, 10 Career Experience

Relevant Experience

- **ASES MCO Oversight and Operations**
  - 2021–present Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico
    - Provide research and recommendations regarding quality measure benchmarking.
- **External Quality Review**
  - 2021–present State of Delaware, Department of Health and Human Services
    - Clinical review of EQRO reports submitted by plans to the State. Assist in design of reporting templates, dashboards, and data collection tools.
- **Delaware Health Care Spending and Quality Benchmarks**
  - 2020–present State of Delaware, Department of Health and Human Services
    - Provide research and recommendations regarding quality measures benchmarking. Perform gap analysis to address overall network adequacy.
- **Quality Innovation Network/Quality Innovation Organization**
  - 2018–2019 Centers for Medicare & Medicaid Services
    - Manage day-to-day activities. Assisted in data analysis, report production, and quality data dashboard design.

Laurie Klanchar, MSN, RN, CRNP, Principal

Summary of Experience

Laurie is a registered nurse practitioner and principal in Mercer's Government Human Services Consulting group. Her areas of expertise include clinical, quality, and operations in the areas of mental health, SUDs, and physical health integration. Her experience ranges from direct care within inpatient and outpatient settings, case management, teaching, and quality management to senior leadership positions within a large statewide behavioral health managed care organization (BH-MCO). Prior to joining Mercer in 2017, Laurie worked in various capacities over 12 years at a BH-MCO that served nearly one million Medicaid lives within 10 contracts.

Education

- 2000 Master of Science in Nursing, University of Pittsburgh
- 1988 Bachelor of Science in Nursing, University of Pittsburgh

Certifications and Licenses

- 2009 Six Sigma Green Belt Certified, Lean Six Sigma Green Belt
- 2000 Certified Registered Nurse Practitioner, Pennsylvania State Board of Nursing
- 1988 Registered Nurse, Pennsylvania State Board of Nursing

Years of Experience

- 4 Mercer Experience, 25+ Career Experience

Relevant Experience

- **External Quality Review**
  - 2021 State of Delaware, Department of Health and Human Services
    - Complete care coordination file reviews for two MCOs, synthesize findings, and make recommendations.
- **Program Evaluation**
  - 2017–2022 Commonwealth of Pennsylvania, Department of Human Services, Office of Mental Health and Substance Abuse Services
    - Lead on-site and desk review for triennial reviews and draft report findings.
    - Manage 1115 SUD waiver implementation and monitoring.
    - Draft an environmental scan of Residential Treatment Facility.
- **Data Monitoring & Quality**
  - 2020–2022 Delaware Health Care Commission (DHCC)
    - Assist developing a Benchmark Implementation Manual including data collection, review, and analysis.
    - Perform as clinical lead for client communication on the quality benchmarks.
    - Assist DHCC in identifying health concerns for the State residents and propose corresponding relevant quality PMs.
    - Conduct contractor performance reviews
  - 2019–2020 State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

- Conduct on-site and desk reviews of a distressed plans program for the clinical operations (utilization management and case management), as identified as a distressed plan.
- Develop comprehensive report of MCO performance, including strengths and areas for improvement, and recommendations for State management and oversight.

- **Program Design, Planning & Strategy**
  - 2018–2019 State of Arizona, Health Care Cost Containment System
    - Provide policy, clinical, and financial consulting on compliance with the Mental Health Parity and Addition Equity Act (MHPAEA), including detailed review of non-quantitative treatment limitations analysis.

Laura Pavlecic, MBA, BSN, RN, Principal

Summary of Experience

Laura has extensive experience in the healthcare delivery system of managed Medicaid and Medicare services within a variety of states and commercial plans. Her areas of expertise are case management, care coordination, utilization management, integration of physical health, BH, and pharmacy. Laura has conducted a number of oversight and compliance reviews to determine readiness for implementation, contractual compliance including EQR, and specific analysis for distressed plans. Laura has provided expertise with the development of monitoring and oversight plans, including report development and quality assurance and performance improvement activities. Laura has worked on the National Committee for Quality Assurance (NCQA) accreditation for health plans in a variety of states, resulting in consistent passing or exceeding expectations.

Education

- 2004 Master of Business Administration, Chatham University
- 1987 Bachelor of Science in Nursing, University of Pittsburgh

Certifications and Licenses

- 1987 Registered Nurse, Commonwealth of Pennsylvania, Department of State Bureau of Professional and Occupational Affairs

Professional Affiliations

- Member, State Board of Nursing

Years of Experience

- 5 Mercer Experience, 25+ Career Experience

Relevant Experience

- **External Quality Review**
  - 2016–present State of Delaware, Department of Health and Human Services
    - Conduct on-site and desk reviews of the MCOs to meet the EQRO compliance review standards and State contractual standards for utilization management, care coordination, and case management. Develop comprehensive ERQ report for clinical areas to provide feedback on findings. Provide ongoing TA on identified contractor areas of opportunity.
    - Develop comprehensive report of MCO performance, including strengths and areas for improvement, resulting in CAPS as part of the EQRO compliance review.
- **Readiness Reviews**
  - 2018–2019 Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico
    - Conduct readiness reviews of five MCOs in advance of program implementation, including reviews of utilization management, case management, and provider network.

    - Develop and implement a readiness review tool, complete a thorough review of the MCOs across a variety of functional areas to assess their readiness, and report findings to Puerto Rico.
  - 2016–2018 State of Kansas, Department of Health and Environment
    - Conduct readiness reviews of five MCOs in advance of program implementation, including reviews of utilization management, case management, and provider network.
    - Develop and implement a readiness review tool, complete a thorough review of the MCOs for utilization management and quality assurance and performance improvement functional areas to assess their readiness, and report findings to the State.
- **Program Design, Planning & Strategy**
  - 2018–2019 Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico
    - Develop updated QMS and the QMS evaluation.
    - Conduct contractor performance reviews.
  - 2019–present State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services
    - Conduct on-site and desk reviews of a distressed plans program for the clinical operations (utilization management and case management), as identified as a distressed plan.
    - Develop comprehensive report of MCO performance, including strengths, areas for improvement, and recommendation for State management and oversight.
  - 2016–2018 District of Columbia, Department of Health Care Finance
    - Conduct on-site and desk reviews of Health Services for Children with Special Needs, Inc. managing the Children and Adolescents Supplemental Security Income program for the clinical operations (utilization management and case management), as identified as a distress plan.
    - Develop comprehensive report of MCO performance, including strengths, areas for improvement, and recommendations for the District on Children and Adolescents Supplemental Security Income program management and oversight.
- **Medicaid/CHIP Policy & Regulations**
  - 2018 Commonwealth of Pennsylvania, Department of Human Services, Office of Mental Health and Substance Abuse Services
    - Provide policy, clinical, and financial consulting to the Commonwealth on compliance with the MHPAEA, including detailed review of non-quantitative treatment limitations analysis.

Rachel Henrichs, Associate

Summary of Experience

Rachel has worked with numerous physical, behavioral, and dental health MCOs in Colorado, Michigan, Utah, and Virginia, interpreting Medicaid and state CHIP regulations and identifying areas of strengths and non-compliance. She also reviewed CAPs and worked with these organizations until identified deficiencies were resolved and full compliance was achieved. She has also conducted on-site record reviews related to denials, appeals, credentialing, recredentialing, and care coordination.

Education

- 2015 Associate of Arts, Arapahoe Community College

Years of Experience

- <1 Mercer Experience, 15 Career Experience

Relevant Experience

- **External Quality Review**
  - 2021 State of Delaware, Department of Health and Human Services
    - Assist with the Information Systems Compliance Assessment of two Medicaid managed care plans, including developing request for information and assessment tools, conducting desk reviews, interviews with key staff, and reporting.
  - 2018 State of Utah, Department of Health
    - Conduct on-site and telephonic record reviews to ensure conformity with federal Medicaid and State CHIP regulations and contract requirements related to denials, grievances, appeals, and credentialing and recredentialing.
    - Audit policies, procedures, meeting minutes, reports, and member materials, and interview key staff members.
    - Review and compare 22 individual health plan reports to ensure consistent scoring methodology among reviewers across all plans.
    - Participate in the development and preparation of the annual technical report of quality, access, and timeliness of EQR activities.
  - 2010–2018 State of Colorado, Department of Health Care Policy and Financing
    - Use statutes, regulations, and contracts to develop audit review tools for Colorado's physical and behavioral health plans.
    - Provide TA to MCO and BH organization staff members to help them understand and prepare for the compliance review process.
    - Conduct on-site record reviews to ensure conformity with federal Medicaid and State CHIP regulations and contract requirements related to denials, grievances, appeals, credentialing and recredentialing, and coordination of care.
    - Collaborate with PIP, HEDIS, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) teams to develop appropriate health plan-specific and Statewide recommendations for quality improvement projects.
    - Participate in development and preparation of the annual technical report of quality, access, and timeliness of EQR activities.

Cindy Ward, MBA, BSN, RN, Principal

Summary of Experience

Cindy is a principal and registered nurse within Mercer's Government Human Services Consulting group and holds a Master's in Business Management degree. Cindy brings integrated physical and behavioral health clinical experience and extensive healthcare clinical and quality experience to the Mercer team. Prior to Mercer, she held a variety of quality and clinical leadership positions with national insurers, and now leads consulting projects, including EQR.

Education

- 2010 Master of Business Administration, Kennesaw State University
- 2005 Bachelor of Science Nursing, Georgia Southern University
- 1995 Associate of Science in Nursing, Armstrong Atlantic University

Certifications and Licenses

- 1995 Registered Nurse, State of Georgia Board of Nursing
- 2011 Registered Nurse, State of Florida Board of Nursing

Years of Experience

- 7 Mercer Experience, 25+ Career Experience

Relevant Experience

- **External Quality Review**
  - 2012–2018 State of Delaware, Department of Health and Human Services
    - Lead clinical and quality aspects of EQR protocols, including PIP evaluation, PMV, compliance, and program integrity reviews.
    - Conduct intensive trainings to MCOs on PIP development and evaluation and quality improvement methods such as rapid-cycle improvement model and the use of lead and lag measures.
    - Lead evaluation of MCO care management, quality management, and utilization review, including integrated BH.
- **Quality & Performance Measurement**
  - 2019–2020 State of New Jersey, Division of Medical Assistance and Health Services
    - Lead an evaluation team to review a managed care plan’s operational effectiveness and provide the State with corrective action recommendations, aiming for performance improvement within their program.
- **Program Design, Planning & Strategy**
  - 2020–present State of Nevada, Department of Health and Human Services, Division of Health Care Finance and Policy
    - Redesign care management to meet the State's QMS and population health goals, with emphasis on vulnerable populations, BH integration, and cultural competency, addressing health disparities, social determinants of health (SDOH), maternal health, and higher accountability for the managed care plans in achieving the State's goals and improved MCO reporting.

- 2014–present Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico
  - Partner with ASES in areas of Medicaid quality, clinical programs, managed care oversight, and clinical quality reporting. Assist ASES in developing and revising their QMS, conducting annual quality management evaluations of the program, and designing the clinical and quality oversight functions within a comprehensive oversight tool. Conduct managed care readiness reviews, update managed care contract requirements, and assist in re-procurement efforts.

- **Financial Analysis & Budget Modeling**
  - 2019–present State of California, Health and Human Services Agency, Department of Health Care Services
    - Provide clinical support for actuarial and financial analysis of new Medicaid programs and program changes.

Katherine Nichols, CPH, LCSW, Senior Associate

Summary of Experience

Prior to joining Mercer in 2020, Katherine worked at the North Carolina Department of Health and Human Services for 10 years, where she served as the manager and Acting Director of multiple divisions within the North Carolina Division of Medical Assistance. Katherine led multiple service level and system level design, implementation, and evaluation projects, including the North Carolina 1115 SUD Demonstration Waiver and the North Carolina 1915 (b)(c) Medicaid waivers.

Education

- 2010 Certificate of Public Health, Johns Hopkins University
- 1999 Masters of Social Work, New York University
- 1994 Bachelor of Arts in Communication and Media Studies, Virginia Polytechnic Institute and State University

Years of Experience

- 1 Mercer Experience, 20 Career Experience

Relevant Experience

- **Medicaid Financing**
  - 2020–present Commonwealth of Pennsylvania, Department of Human Services, Office of Mental Health and Substance Abuse Services
    - Complete a national review and environmental scan of payment methodologies for Individual Placement and Support, an evidence-based supported employment model, to determine funding options and ways to ensure fidelity to the evidence based practice; includes development of a briefing document.
- **Medicaid/CHIP Policy & Regulations**
  - 2020–present Commonwealth of Pennsylvania, Department of Human Services, Office of Mental Health and Substance Abuse Services
    - Organize and lead a Commonwealth-wide steering committee and targeted focus groups to solicit stakeholder input and recommendations pertaining to telehealth services; includes identification and solicitation of participants, development of interview guides and meeting materials, capture and synthesis of stakeholder input, analysis of themes and findings, and development of a briefing document.
  - 2017–2020 State of North Carolina, Department of Health and Human Services, Division of Mental Health Developmental Disabilities and Substance Use Services
    - Provide oversight of State mental health, substance use, and developmental disability system.
    - Lead State policy development for mental health, substance use, developmental disability, and prevention of high cost medical expenses.
    - Collaborate with the Department of Health and Human Services leadership, members of the North Carolina General Assembly, and other stakeholders to develop budget and clinical guidelines for State policy.
    - Oversee clinical planning for State and federal funding of the North Carolina BH system.

- **Waiver Design & Development**
  - 2021–present State of Colorado, Department of Health Care Policy and Financing
    - Design and implement the monitoring protocol for Colorado's 1115 SUD Waiver Monitoring Protocol.
    - Develop CMS Monitoring Protocol.
    - Complete CMS required quarterly and annual reports.
  - 2020–present State of North Carolina, Department of Health and Human Services, Division of Mental Health Developmental Disabilities and Substance Use Services
    - Assist State in determining policy and addressing requests from CMS for 1135 and 1915(c) Appendix K waivers to address COVID-19.
- **Program Design, Planning & Strategy**
  - 2020–present State of Ohio, Department of Medicaid
    - Develop an Ohio-specific assessment tool for children (Child and Adolescent Needs and Strengths [CANS]) for OhioRISE, a managed care program specific to children.
    - Assess and assist State in readiness for transition to managed care, including review of staffing and policies and procedures to ensure appropriate business processes are in place to oversee new managed care vendors.
    - Assist in development of CANS tool, working with Ohio Medicaid and the Praed Foundation, developers of the tool.
    - Research best and promising practices to address emergency department (ED) boarding challenges and to increase community-based capacity for individuals in crisis; includes development of a briefing document.
- **Stakeholder Engagement**
  - 2021–present Puerto Rico, Health Insurance Administration, Administración de Seguros de Salud (ASES) de Puerto Rico
    - Develop a network adequacy review and report for ASES for Medicaid providers in Puerto Rico.
    - Design stakeholder interviews with MCOs and sister agencies in Puerto Rico.
    - Develop an analysis of existing providers.
    - Develop recommendations for alternative payment arrangements, workforce development, and interagency communication to improve the Medicaid program's provider network access.
    - Identify SDOH preventing access to care and potential mitigation strategies.

Jason E. Vogler, PhD, MA, BA, NADD-DDS, CSSBB, Principal

Summary of Experience

Jason's experience include state-level administration, managed care, work as a provider, and academic research. He worked at the North Carolina Department of Health and Human Services for 10 years, during which time he served as the Senior Director of Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. His experiences have included the full spectrum of policy making, service definition creation, service implementation, clinical service delivery, evaluation, research, and various managed care functions (e.g., utilization management and quality review) for Medicaid.

Education

- 2007 Doctor of Philosophy in Psychology, University of Nebraska
- 2004 Master of Arts in Psychology, University of Nebraska
- 2001 Bachelor of Arts in Psychology, University of North Carolina at Chapel Hill

Certifications and Licenses

- 2021 Dual Diagnosis Specialist, National Association for the Dually Diagnosed
- 2015 Six Sigma Black Belt, Aveta Business Institute
- 2008 Licensed Psychologist; Health Services Provider, North Carolina Psychology Board

Years of Experience

- <1 Mercer Experience, 20 Career Experience

Relevant Experience

- **Readiness Reviews**
  - 2021–2022 State of Ohio, Department of Medicaid
    - Conduct readiness reviews of seven MCOs in advance of Ohio Medicaid Managed Care reprocurement, including reviews of Utilization Management, Medical Services, Population Health and Quality, and State of Emergency Requirements.
- **Quality & Performance Measurement**
  - 2018–2020 Murdoch Developmental Center
    - Provide direct clinical services, including psychological evaluations and admissions screenings; behavior, cognitive, diagnostic, and functional assessments; and treatment.
    - Participate in multidisciplinary teams, person-centered planning, skills training, and various quality assurance/improvement activities; lead groups such as social skills and CIRCLES curriculum.
    - Monitor and present on behavioral data.
- **Clinical Best Practices — Population & Service Specific**
  - 2020–2021 Cardinal Innovations Healthcare
    - Perform managed care medical necessity reviews and decisions, complex case consultations, reconsideration reviews and appeals; utilization management and care coordination recommendations; clinical consultation; and Innovations Waiver (HCBS) Registry of Unmet Needs determinations.

Elizabeth Collins, MSN, BS, BA, RN, Senior Associate

Summary of Experience

Elizabeth has extensive experience in the healthcare delivery system, including direct service and community-based services. Her areas of expertise include vulnerable populations, systems of care, care coordination, needs assessment, quality improvement, and family and stakeholder engagement. Elizabeth has consulted on autism service delivery, home visiting, clinical implications for legislative change, and clinical efficiencies. Elizabeth worked in the New Hampshire Department of Health and Human Services for 27 years, where she was responsible for improving systems of care, reporting (agency, legislative, and federal) and monitoring, and oversight of Medicaid managed care services for vulnerable populations, including the quarterly review of grievances and appeals.

Education

- 2007 Master of Science in Nursing Leadership, University of New Hampshire
- 1992 Bachelor of Science in Nursing, University of Southern Maine
- 1987 Bachelor of Arts in Government, Wells College

Certifications and Licenses

- 1992 Registered Nurse, New Hampshire Board of Nursing — Office of Professional Licensure and Certification

Years of Experience

- 1 Mercer Experience, 25+ Career Experience

Relevant Experience

- **Readiness Reviews**
  - 2020–2021 State of Ohio, Department of Medicaid
    - Analyze current and planned operations, identify strengths and opportunities, and issue recommendations for State's consideration and implementation.
  - 2019–present State of Delaware, Department of Health and Human Services
    - Coordinate and participate in a follow-up review of managed care operations to evaluate the integration of acute medical services for individuals with I/DD receiving residential habilitation services.
- **Capitation Rate Development**
  - 2020–present Commonwealth of Pennsylvania, Department of Human Services, Office of Long Term Living
    - Collaborate with team members to provide input and assessments that result in the incorporation of clinically sound assumptions in project deliverables.
    - Provide guidance and expertise to identify clinical patterns from data analysis and dependencies within systems that impact decisions and risks.
    - Support client review, identification of priorities, and preparation for MCO contract negotiations.
  - 2019–present State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services

    - Provide guidance and expertise to identify clinical patterns from data analysis and dependencies within systems that impact decisions and risks.
    - Collaborate with team members to provide input and assessments that result in the incorporation of clinically sound assumptions in project deliverable.
- **Risk Adjustment**
  - 2019–present Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health
    - Provide guidance and expertise to identify clinical patterns from data analysis and dependencies within systems that impact decisions/risks/issues.
    - Collaborate with team members to provide input and assessments that will result in the incorporation of clinically sound assumptions in project deliverables.
- **Data Monitoring & Quality**
  - 2020 State of Delaware, Department of Health and Human Services
    - Provide TA on the current MCO Critical Incident reporting and DMMA monitoring processes.

Laura Salkowe, Associate

Summary of Experience

Laura was employed with the New York State Office of Mental Health, where she gained over seven years of experience working on many of the agency's critical health systems transformations, such as bringing adult and children's Medicaid mental health services under the responsibility of MCOs contracted with the State of New York. Her responsibilities included project planning, collaboration with multiple agencies, developing and training review teams to evaluate MCO readiness, and post-implementation troubleshooting. In addition, Laura has knowledge of Medicaid Managed Care compliance and developing oversight processes.

Education

- 2012 Bachelor of Arts in Political Science, University at Albany
- 2014 Master of Public Administration, University at Albany

Years of Experience

- 1 Mercer Experience, 7 Career Experience

Relevant Experience

- **Contractor Performance**
  - 2014–2021 New York State Office of Mental Health
    - Conduct systems readiness reviews of 15 MCOs in advance of adult and children's BH services transitioning to managed care, including reviews of eligibility and enrollment processing, claims processing, care management systems, and reporting, which provide feedback to State leadership and MCOs on gaps in capabilities and processes, along with prioritization of resolution of the identified concerns.
    - Develop comprehensive report of State Medicaid MCO performance, including strengths and areas for improvement, resulting in recommendations and corrective action items.
    - Develop and implement a readiness review tool.
    - Conduct operational survey of MCOs, including enrollment, claims processing, network adequacy, organization, personnel, vendor management, member services, and quality management.
    - Evaluate new State and federal regulations for Medicaid managed care and oversight of MCOs, resulting in recommendations regarding impact and implications for the State.
    - Design program strategy for BH services carving in to Medicaid Advantage Plus Plans, including development of program requirements for MCOs, processes, procedures, and recommendations.
    - Perform scheduling and facilitation of stakeholder feedback sessions with MCOs for State, including development of presentations, resulting in high participation rates and comprehensive feedback.

Scott Banken, MBA, CPA, Principal

Summary of Experience

Scott currently leads the Reporting and Monitoring team as part of Mercer's Actuarial/Financial sector and is responsible for development of MCO financial oversight plans, detailed financial reporting requirements, audits, and cost studies. Scott also actively facilitates multi-payer work groups to develop, standardize, and measure the effectiveness of VBP programs.

Education

- 2002 Masters of Business Administration, University of Minnesota
- 1993 Bachelor of Arts in Accounting, University of Saint Thomas

Years of Experience

- 8 Mercer Experience, 23 Career Experience

Relevant Experience

- **Cost Reporting Development & Monitoring**
  - 2019–present State of California, Health and Human Services Agency, Department of Health Care Services
    - Conduct audits of base financial data in accordance with 42 CFR 438.602(e) and provide actionable feedback on quality improvement opportunities for 24 MCOs.
  - 2016–present State of Delaware, Department of Health and Human Services
    - Develop financial reporting requirements including templates and reporting guides.
    - Monitor MCO financial activity.
    - Perform operational reviews of managed care program integrity units using an EQR methodology.
    - Assist in the completion of the State Program of All-Inclusive Care for the Elderly organization application.
  - 2016–present State of Minnesota, Department of Human Services, Mental Health Division
    - Create and maintain Certified Community Behavioral Health Center cost report templates, document audit and review procedures, and train clinics on the proper completion of the reports in accordance with CMS cost principles.
  - 2014–present Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health
    - Create financial reporting templates for the SCOs and One Care dual programs to support financial oversight and rate-setting.
  - 2012–2018 State of Louisiana, Department of Health
    - Develop financial reporting requirements, including templates and reporting guides and agreed-upon procedures for MCOs.
    - Review and analyze MCO financial reports and present results to the State to monitor profitability, accuracy, solvency, efficiency, and contractual compliance.

Brenda Jenney, PhD, MS, BS, Senior Associate

Summary of Experience

Brenda combines statistical knowledge and SAS programming skills with over seven years of analytical expertise to assist with clients' data management and analysis needs. Brenda supports rate-setting, risk adjustment, and evaluations of Medicaid programs. Her skills include analyzing and interpreting healthcare data, including claims, eligibility, pharmacy, health assessment, and survey data, with descriptive and inferential statistical methods. She is a team member for the State of New Jersey client and has supported analytical projects for many other Medicaid programs, including Delaware, Louisiana, Montana, New Mexico, and New York.

Education

- 2009 Doctor of Philosophy in Statistics, Arizona State University
- 2005 Master of Science in Statistics, Arizona State University
- 1996 Bachelor of Science in Mathematics, Duke University

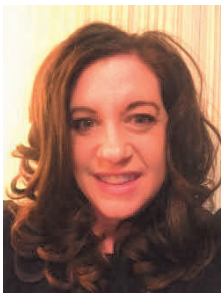
Years of Experience

- 8 Mercer Experience, 15 Career Experience

Relevant Experience

- **Program Evaluation**
  - 2021–present State of Colorado, Department of Health Care Policy and Financing
    - Develop driver diagrams and research design tables with testable hypotheses and measures for Section 1115 SUD demonstration evaluation design.
  - 2021–present St. Louis Regional Health Commission
    - Conduct interim evaluation with descriptive and inferential statistical analyses and data visualization for Gateway to Better Health Section 1115 demonstration.
  - 2019 State of New Mexico, Human Services Department
    - Develop driver diagrams and research design tables with testable hypotheses and measures for Section 1115 demonstration evaluation design, including the SUD demonstration.
  - 2019 State of Delaware, Department of Health and Human Services
    - Develop driver diagrams and research design tables with testable hypotheses and measures for program evaluation of a pilot program for the treatment of chronic lower back pain with alternative therapies, such as acupuncture and massage.
  - 2018 Citi
    - Compare return on investment in health management programs with descriptive and multi-variable statistical techniques, including case mix adjustments, propensity score matching, linear regression, and difference in difference analysis.
  - 2015–2017 State of Oklahoma, Health Care Authority
    - Compare program interventions on ED utilization with descriptive and multi-variable statistical techniques, including logistic regression and analysis of covariance.
- **Risk Adjustment**
  - 2020–present Commonwealth of Massachusetts, Executive Office of Health and Human Services, Department of Public Health

    - Develop and implement functionally-based risk adjustment methodology for the SCO's community LTSS program using the Minimum Data Set — Home Care assessment, including data collection, model development, and risk score development.
  - 2017–present State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services
    - Implement health-based risk adjustment using the Chronic Illness and Disability Payment System (CDPS) plus Pharmacy model, including the development of New Jersey-specific CDPS cost weights.
    - Develop and implement functionally-based risk adjustment methodology for managed LTSS program using New Jersey Choice assessments, including data collection, model development, and risk score development.
  - 2013–2017 State of New York, Department of Health
    - Develop and implement functionally-based risk adjustment methodology for managed long-term care (LTC) program using the Uniform Assessment System for New York, including data collection, model development, and risk score development.
- **Pharmacy Provider Reimbursement**
  - 2020 State of Minnesota, Department of Human Services
  - 2019–2021 State of Missouri, Department of Social Services, MO HealthNet Division
  - 2019 State of Tennessee, Department of Health and Human Services
  - 2018 State of Colorado, Department of Health Care Policy and Financing
  - 2018 State of Louisiana, Department of Health
  - 2017 State of Oregon, Oregon Health Authority
    - Develop and conduct a Cost of Dispensing survey and analyze survey data to develop Medicaid dispensing fee reimbursement rates.
- **Regulatory Compliance & Monitoring**
  - 2017–2018 State of California, Health and Human Services Agency, Department of Health Care Services
    - Develop data collection strategies, statistical analyses, and reporting methodology for the settings assessment methodology in California's Statewide Transition Plan for compliance with the CMS HCBS Final Rule.



Jennifer A. Lenz, MPH, CHCA

Qualification Highlights:
A highly qualified professional with more than 19 years of experience in the healthcare industry, with expertise in implementing and managing EQR activities, managing teams, and driving quality improvement initiatives. Experience in conducting evaluation of public health programs, compliance reviews, and PMV. Has a working knowledge of Medicaid, Medicare, CHIP, Marketplace, Medicare Medicaid plan demonstration projects, 1115 waivers, ACOs, managed LTSS, and federal employee benefit plans. Experience as a NCQA Certified HEDIS Compliance Auditor (CHCA), CMS data validation evaluator, and Utilization Review Accreditation Commission (URAC) specialty pharmacy reviewer with extensive knowledge of PMs, information systems, and auditing techniques.

Professional Experience:

- **Quality Review Solutions, LLC. (QRS), President/Independent Consultant (5/2015–present)**: Serves as an independent consultant for conducting various audit and quality improvement activities. Has responsibility for interfacing with NCQA Licensed Organizations to conduct HEDIS Compliance Audits™, CMS data validation audits, URAC specialty pharmacy audits, and PMV audits for Commercial, Medicare, Medicaid, CHIP, and Marketplace populations. Interfaces with EQROs to conduct compliance and PMV audits, provide staff training, and TA. Has served as subcontractor to EQROs for the states of California, Virginia, Massachusetts, Florida (CHIP), and Maryland. Provides consultation to NCQA and the Centers for Disease Control & Prevention (CDC) on the Million Hearts Hypertension Control Project.
- **Health Services Advisory Group, Inc**. **(HSAG), Executive Director, State & Corporate Services (11/2008–8/2015)**: Served as the EQR primary point of contact for the Georgia Department of Community Health with oversight of Project Directors who served as main points of contacts for the states of California, Ohio, and Virginia. Had responsibility for oversight of the HSAG teams for PIPs, community collaboratives, and audits. This included communications, project planning and budgeting, tracking project timelines and task schedules, overseeing timely and quality contract deliverables, developing written reports, identifying project improvement opportunities, developing and facilitating quality improvement activities, and coordination and communication with internal departments on project activities.
  - Provided TA on strategic planning and QMS development to Medicaid state clients and health plans with project facilitation that incorporated logic models and key driver diagrams, as well as introduced quality improvement science techniques to evaluate quality improvement effectiveness.
  - Served as the principal investigator on the Ohio Department of Health, Quality Improvement Project for Type II Diabetes Mellitus Post-Partum Screening Among Women with a History of Gestational Diabetes Mellitus.
- **HSAG,** Associate Director (7/2010–9/2011)/Project Manager (11/2008–7/2010) Project Manager**:** Served as the associate director/project manager for HSAG's EQRO contract with the State of California.

- **Arizona Department of Health Services, Bureau of Chronic Disease Prevention and Control, Well Woman HealthCheck Program, Well Woman HealthCheck Program Director (1/2006–11/2008)**: Responsible for implementation of the National Breast and Cervical Cancer Early Detection Program in Arizona providing breast and cervical cancer screening and diagnostics to approximately 8,000 low-income, uninsured, and underinsured women annually. Oversaw cooperative agreement requirements with the CDC for all aspects of the program, including program management, professional development, public education, recruitment, quality assurance, screening, tracking, case management, surveillance, and evaluation. Developed the annual work plan containing specific goals, activities, and PMs for the program. Identified grant opportunities, wrote applications for grant funding, and oversaw implementation and reporting of grant activities. Secured more than $1 million dollars in nonfederal grants between 2007 and 2008. Responsible for Arizona Proposition 303 (tobacco tax) funds, including project management, budget management, development of evaluation plan, and surveillance activities.
- **PacifiCare Health Systems, Desert Region (AZ, NV, CO), Regional Project Manager, Healthcare Quality (10/2002–1/2006)**: Responsible for project management of NCQA accreditation for the Desert Region, including knowledge of regulatory standards related to quality improvement, utilization management, credentialing, and member rights and responsibilities. Provided training to internal staff related to accreditation requirements and was responsible for coordination of all aspects of audit preparation including mock audits and final review. Prepared annual quality improvement documentation, including work plan, program description, and program evaluation. Participated on community collaborative project with multiple state, private, and nonprofit agencies. Performed ambulatory medical record reviews in physician offices for regulatory compliance.

Education:
- Master of Public Health in Health Administration and Policy, University of Arizona, Tucson, Arizona, 2004
- Bachelor of Science in Psychology, Arizona State University, Phoenix, Arizona, 1997

Certifications:
- Certified HEDIS Compliance Auditor; 10/2011–Present
- Certified Master Trainer for the Chronic Disease Self-Management Program, Stanford University, training 2/2007, certification 4/2008

Strategic Advisors

Dr. Laura K. Nelson, MD, Principal

Laura brings extensive Medicaid managed care clinical and administrative expertise to the Mercer team in the areas of mental health, SUDs, and I/DDs. Laura is a board-certified psychiatrist with experience ranging from direct care within inpatient and outpatient settings to state-level executive leadership positions in public health, BH, and I/DD. With Laura as the lead, GHSC's Clinical and Behavioral Health Services team has worked in the federal healthcare space with the Defense Health Agency as well as with 30 states and territories on physical health, BH, and LTSS projects. Laura has provided TA to Defense Health Agency and state Medicaid, BH, and I/DD agency staff in Arizona, Delaware, Louisiana, Massachusetts, Missouri, New Jersey, New York, North Carolina, Ohio, Pennsylvania, South Carolina, and Washington to design and implement program and policy changes that support cost-effective community-based services, integrated care, and system transformation, and increase the use of clinical best practices (for example, medication assisted treatment, assertive community treatment, supportive housing, supported employment, applied behavior analysis).

Heather Huff, MA, Principal

Heather leads clinical quality, clinical efficiency, and BH projects for Medicaid/CHIP and LTC populations. Heather has led compliance, quality measurement, performance-based contracting, and TA activities for Connecticut, Delaware, the District of Columbia, Florida, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Pennsylvania, and Texas. She has led program evaluation projects for New Mexico, Pennsylvania, and the St. Louis Regional Health Care Authority. Her knowledge of nationally-recognized PMs, accuracy with data analysis, ability to translate data into actionable steps, leadership, and project management skills results in exceptional deliverables for client projects.

Holly Dolgaard, MBA, CHC, CHPC, Principal

Holly directs the team of SMEs in EQR protocols, health plan information systems, claims audits, encounter data quality and validation, encounter data analytics, and state-managed MMIS. Holly has facilitated innovations in healthcare agency contracts and procurements. Holly's recent specialty projects focus on systems, data, and health plan operations for the advancement of Mercer's clients' ability to drive improvement in healthcare data; outcomes include the development of the District of Columbia's Medicaid encounters quality performance metrics and improving the District's Office of Healthcare Ombudsman and Bill of Rights commercial insurer grievance and appeals annual reporting systems. Holly worked with another EQRO, leading systems readiness and compliance reviews for the CMS Dual Eligibility Demonstration in 12 states and the managed Medicaid programs for five states before transitioning to supporting federal and state regulators.

Maggie Wolfe, MPH, Principal

Maggie is a principal and Medicaid policy and operations consultant in Mercer's Government Human Services Consulting practice in the Washington, DC office. For over nine years, Maggie has provided guidance to state Medicaid agencies in their efforts to design and launch new program initiatives, engage stakeholders, and comply with new federal regulations. Maggie has successfully guided states through process assessments and operational improvement projects, managed care and other procurements, new program design initiatives, and stakeholder engagements. During her time with Mercer, she has supported large policy and operations projects in states such as Connecticut, Delaware, Idaho, Kansas, North Carolina, and Ohio. Maggie served as the Assistant Secretary for Family Health and Health Promotion at the Puerto Rico Department of Health.

Gowri Shetty, MS, MPH, Principal

Gowri is a highly experienced, results-driven, versatile leader with expertise in strategic analytics, health economics, quality management, and outcomes measurement. She is a critical thinker with demonstrated strength in advising organizations during contracting and expanding economies and brings extensive experience in healthcare analytics, informatics, research methodology, risk mitigation, quality improvement, program evaluation, strategic planning and translation, and dissemination of data. Gowri's core competency is in creating, scaling, and executing multidisciplinary strategies geared towards performance improvement and cost containment and has deep expertise in analyzing survey and administrative data, including large national datasets, as well the development, implementation, and evaluation of population health solutions for public and commercial sectors.

Provide a statement of whether the respondent intends to use subcontractors to meet the respondent's requirement of any contract awarded pursuant to this RFP. Please list the following: Name of the subcontractor; A description of the scope of each subcontractor involved A letter from each subcontractor assenting that has been proposed as subcontract.

To complement our in-house resources, we are excited to add to our team Jennifer Lenz of Quality Review Solutions, LLC (QRS). Ms. Lenz is a NCQA CHCA and has over 10 years of recent senior-level experience managing high visibility projects with state agencies, extensive knowledge of PMV, and managing a HEDIS and PMV audit team. A letter confirming QRS will subcontract to Mercer is located on the following page.

Subcontractor Information	
Business Name:	Quality Review Solutions, LLC.
Contact Person's Name and Title:	Jennifer Lenz, MPH, CHCA
Mailing Address:	4527 E. Villa Maria Dr. Phoenix, AZ 85032
Scope of Work	QRS will Conduct HEDIS Compliance Audits, CMS data validation audits, and PMV audit.

January 6, 2022

Jessica Osborne
Principal
Mercer Health & Benefits LLC
2325 E. Camelback Road, Suite 600
Phoenix, AZ 85016

Dear Ms. Osborne:

Quality Review Solutions, LLC (QRS) is pleased to provide this letter as a proposed subcontractor to Mercer Health & Benefits LLC (Mercer) under your bid as prime contractor for the Puerto Rico External Quality Review Organization Selection Request for Proposal (RFP), 2021-PRMP-RFP-002.

Mercer intends to use subcontractors to meet the respondent's requirement of any contract awarded pursuant to this RFP. QRS agrees to subcontract to Mercer for this work.

As required by the RFP, this letter provides the following required information:

Name of the subcontractor: Jennifer Lenz of Quality Review Solutions, LLC (QRS)
4527 E. Villa Maria Dr. Phoenix, AZ 85032

Description of the scope of work: QRS will Conduct HEDIS Compliance Audits™, CMS data validation audits, and PM validation audit

Should you have any questions regarding the information provided, please do not hesitate to contact me.

Sincerely,

Jennifer Lenz
President
Quality Review Solutions, LLC.

QUALITY REVIEW SOLUTIONS, LLC.
4527 E. VILLA MARIA DR. PHOENIX,AZ 85032

Provide three (3) customer references from individuals or entities (who are not current or former officials of the Government of Puerto Rico) for projects similar to the services sought under this RFP and which represent largest accounts serviced by the respondent. All references must be provided using the standard reference questionnaire included as Appendix 5: Reference Questionnaire in the RFP. Each reference questionnaire must be completed and signed. Puerto Rico will not review more than the number of references required in this RFP (3).

References were requested and provided following the instructions in Appendix 5. Please find the sealed Reference Questionnaires as an inclusion in the original binder copy of our response.

Provide documentation of the respondent's commitment to diversity, example: Provide a description of the respondent's existing internal programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities including, women, veterans, disabled veterans, Latino Community, Asian, African American, LGBTQ Community, etc. This may include contractors or subcontractors. Note: This section is not a prerequisite and is not required to be able to receive a maximum evaluation score. However, if complied with in satisfactory form, there will be a bonus of two (2) points.

Embracing diversity at Mercer and striving to ensure inclusiveness are foundational elements in our culture and engrained in everything we do. We view diversity in the broadest sense — which includes, but is not limited to, gender, race and ethnicity, sexual orientation, gender identity, disability, and generation, as well as traits like thinking style, geography/business line, background, and industry. Each person, no matter who we are or where we came from, is unique with multiple dimensions.

Data-driven action plan, amplified focus on diversity

At Mercer, we use workforce analytics and data-driven insights to define our strategy and monitor key diversity metrics that help us create a more diverse workplace and inclusive culture. Leaders at the top and across the firm are accountable for driving inclusion and diversity (I&D) actions, such as increasing diverse representation in key roles and on client teams through hiring, development, and promotion. To help achieve this, leaders have created visible I&D goals around hiring, advancement, and retention, where results influence leader pay and performance. Beginning in 2021, Mercer publicly disclosed our global diversity data for gender and our US ethnic and racial diversity. Our I&D strategy is integrated into our People strategy and aligned with overall business goals. Historically, we have had a strong focus on gender and we recently refreshed our overall action plan to amplify focus on ethnic and racial diversity. We use a four-point framework to drive toward achieving our diversity goals (outlined below).

Diversity metrics dashboard: We monitor key metrics — **gender** (global) and **ethnic and racial diversity** (representation, hiring, promotion, key roles, people managers, and revenue generators and 100% major bid teams) — on a quarter-by-quarter basis to ensure positive progression or to make adjustments if needed. Our representation of gender: 55% women, 45% men; 43% of Principal level and above are women.

Approach to professional development, learning, and growth opportunities for colleagues

A strong talent pipeline constantly renews Mercer. For Mercer to remain competitive, we must constantly renew our pipeline of qualified leadership and technical talent. As part of our ongoing workforce management efforts, we monitor new hires, promotions, and retention levels across multiple people variables, including race, age, tenure, and business experience.

While our People function (human resources) is a key enabler, our leaders and people managers are responsible and accountable.
Training, development, mentorship, and on-the-job experience allow all colleagues, at every level, to learn, grow, and advance. In addition to mandatory training for leaders and managers, all colleagues receive ongoing refresher and enrichment training throughout the year. Learning to address unconscious bias and build cultural competence is mandatory for our leaders and people managers.

Business Resource Groups

Our business resource groups (BRGs) are groups of colleagues who voluntarily work together with a focus on supporting our colleagues, clients, and communities and are open to all colleagues. We have six BRGs globally. They are:

- Women@Mercer
- Racial & Ethnic Diversity
- Pride (LGBTQ+)
- Rising Professionals Network (young professionals)
- AccessABILITIES at Mercer (people with disabilities and care givers)
- Mercer Cares (community-focused volunteers)

Social impact in diverse communities

We have a strong culture of corporate citizenship and volunteerism within our firm. We enable our colleagues to contribute directly to communities and causes that matter to them.

On a corporate level, our primary focus is helping people and communities at risk through education and disaster relief. However, we also encourage colleagues to volunteer their time and resources — individually and collectively — to local, national, and global causes of interest. We do this through providing:

- Paid time off to volunteer for every colleague.
- A volunteer rewards program.
- A matching gifts program.
- A volunteer platform that connects colleagues with volunteer opportunities.
- Pro bono consulting opportunities in various parts of the organization.

Our supplier diversity program recognizes many different classifications when referring to supplier diversity. These include, but are not limited to:

- Minority Business Enterprises with specific minority classification.
- Woman and Minority Women Owned Business Enterprises.
- Small Disadvantaged Business SBA 8(a).
- Veteran Owned/Disabled Veteran Owned.
- Certified Disadvantaged Disabled Owned.
- Historically Black Institution Certified HUB Zone.

Section 3
Section C: Technical Qualifications

A Proposal Evaluation Team member will independently evaluate and score the response to each item. Each evaluator will use the following whole numbers for scoring each item (using an example 0-3 point scale):

0 points – Poor

1 point – Fair

2 points – Satisfactory

3 points – Excellent

Respondents Legal Name: **Mercer Health & Benefits LLC**

Table 5: Technical Qualifications

Response Page Number	Reference	Item	Item Score
Pages 58, 59, and 60	Proposed Staff Areas of Expertise: 60, Resumes: pages 27 – 51	Please provide a summary of the staff' proposed for this project demonstrated experience and knowledge of Medicaid beneficiaries, policies, data systems and processes. 42 CFR 438.354(b)(1)(i), 42 CFR438.356(b).	
Pages 61 and 62	Proposed Staff Areas of Expertise: 60, Resumes: pages 27 – 51	Provide a summary of the staff' proposed for this project demonstrated experience and knowledge of managed care delivery systems, organizations, and financing. 42 CFR 438.354(b)(1)(ii), 42 CFR438.356(b).	
Pages 62 and 63	Proposed Staff Areas of Expertise: 60, Resumes: pages 27 – 51	Provide a summary of the staff' proposed for this project demonstrated experience and knowledge of quality assessment and improvement methods. 42 CFR 438.354(b)(1)(iii) 42 CFR 438.356(b).	
Page 64	Proposed Staff Areas of Expertise: 60, Resumes: pages 27 – 51, Appendix E Focus Study: Pages 291 – 333	Provide a summary of the staff' proposed for this projects demonstrated experience and knowledge of research design and methodology, including statistical analysis. 42 CFR 438.354(b)(1)(iv) 42 CFR438.356(b).	
Page 65, 66		Provide a narrative that demonstrates that the EQRO have sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.42 CFR 438.354(b)(2) 42 CFR438.356(b).	

Response Page Number	Reference	Item	Item Score
Page 66		Provide a staffing summary plan which demonstrates that the EQRO have clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractor. 42 CFR438.354(b)(3) 42 CFR 438.356(b)	
Page 66 through 73	Sample Work Plan: Page 70 and 71	Provide a narrative that illustrates the respondent's understanding of PRMP's requirement and project schedule.	
Page 73 through 77		Describe the detailed process to be used for conducting and completing the MCO annual quality survey. Respondent will have to include the proposed data collection tool and the format to be used.	
Page 77	Appendix C: Delaware Technical Report Pages 113 – 266	Provide a redacted copy of a completed annual quality review of a Medicaid MCO and the corresponding executive summary demonstrating how the respondent designed and implemented a tool capturing all Centers for Medicare & Medicaid Services (CMS) requirements. The sample provided must use a survey tool developed by the EQRO in house staff.	
Pages 77 and 78		Describe the data collection tool and the reporting format the proposer would use for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) annual evaluation report. Include sample tools and reports for review.	
Pages 78, 79, and 80		Describe the data collection tool and the reporting format the respondent would assess network adequacy and delivery of health benefits in accordance with each MCO contractor risk agreement, please include a sample.	
Pages 80 and 81		Provide a detailed description of the process the respondent would use to validate the accuracy of the provider-related information submitted by each MCO, if possible, submit tools and report format that would be used for this project.	
Pages 81, 82, and 83		Provide examples of technical assistance that would be offered to both the MCOs and PRMP staff. Also provide explanation of how the need for technical assistance would be assessed.	
Page 83	Appendix D: Sample Comparative Analysis Pages 267 – 290	Provide sample of a comparative analysis the respondent has completed on Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, or other similar data.	
Page 83 through 87		Describe the respondent's process for validation of each MCO's performance improvement projects. Include proposed reporting format and protocols used.	
Page 87	Appendix C: Delaware Technical Report Pages 113 – 266	Provide a redacted copy of an EQRO Technical Report that was prepared by the respondent.	
Page 87 through 92	Appendix C: Delaware Technical Report Pages 113 – 266	Describe how the respondent will fulfill the CMS requirement for validation of MCO performance measures utilizing HEDIS specifications.	

Response Page Number	Reference	Item	Item Score
Pages 92 and 93	Appendix E: Focus Study Pages 291 – 333	Provide a work product sample which was collaborative effort between the respondent's biostatistician, epidemiologist, medicine doctors and other EQRO staff. Information/identifiers should be stricken from the document prior to submission.	
Pages 93 and 94		Describe how the respondent will train and educate staff regarding contractor responsibilities described in the scope of the contract.	
Page 94		Describe how the respondent will monitor and ensure inter-rater reliability among the audit staff. Describe internal controls to help assure accuracy and completeness of required reporting.	
Pages 95 and 96		Describe any current or previous EQRO experience with population health or disease management evaluation methods. Describe how the respondent will monitor and provide feedback to PRMP regarding the efficacy of MCO population health and or disease management protocols and interventions.	
Page 96		Describe the mechanism the respondent will use to remain current on state and federal requirements related to MCO's.	
Page 97, 98, and 99	Appendix B: Statement of Recoverability pages 105 – 112	Describe ongoing internal controls to safeguard access to data as well and the respondent contingency plan for data systems failure in any critical EQRO areas.	
Pages 99 and 100		Describe in detail how the respondent would plan and host meetings with MCOs and interrelated oversight agencies.	
Page 100		Provide narrative describing that respondent is QIO or QIO like entity as required by federal law for services contained in this procurement, along with any proof of designation.	
Total Points for Section C Maximum number of section points = 72			

The total maximum points possible for this section is 72 section points. This section is weighted 60% of the total possible response score of 100 response points. An example calculation of the total response points awarded based on a perfect section score is:

$$\frac{\text{72 section points}}{\text{72 section points}} \times 60\% \times 100 = 60 \text{ response points}$$

Respondent Signature:_____

Printed Name and Title:_____

Date:_____

Table 5: Technical Qualifications

Please provide a summary of the staff' proposed for this project demonstrated experience and knowledge of Medicaid beneficiaries, policies, data systems and processes. 42 CFR 438.354(b)(1)(i), 42 CFR 438.356(b).

The proposed Mercer team exceeds experience and competency requirements to provide the Puerto Rico Medicaid Program (PRMP) with optimal External Quality Review (EQR) services. We bring our knowledge of, and participation in, the transformation of other Medicaid managed care programs, an understanding of where PRMP is going, and ongoing participation in advancements for quality improvement. Our key EQR project leads, Lois Heffernan and Jennie Echols, have been involved with EQR activities for over 10 years. Dr. Echols is a Certified Professional in Healthcare Quality.

The table below, "Proposed EQRO Staff," provides a summary of Mercer's proposed core team members, demonstrating experience and knowledge of Medicaid beneficiaries, policies, data systems, and processes.

Medicaid Beneficiaries

Our proposed team includes experts representing multiple disciplines, which will provide PRMP with exceptional expertise and experience working with Medicaid populations. Our EQR team includes past Medicaid state officials, staff with experience working as Managed care executives, experts in healthcare policy, experience working with the Centers for Medicare & Medicaid Services (CMS), and networking partnerships with current CMS staff. All proposed staff have extensive experience working with Medicaid beneficiaries, as Mercer Government Human Services Consulting (GHSC) serves Medicaid agencies almost exclusively. Our EQR team is well-versed in the variety of populations that may be encompassed under a single Medicaid program and we use that knowledge to ensure that resources spent to improve the quality, access, and timeliness of services result in meaningful member and provider experience and improved health outcomes.

Medicaid Policies

Mercer's proposed EQR team of consultants has experience addressing issues of federal compliance and opportunities to leverage EQR to inform and drive policy. Our EQR consultants are actively engaged with a number of states to usher in the new quality landscape that emphasizes value over volume, social determinants of health (SDOH), and health equity. We work with quality-focused organizations to develop and implement innovative models aimed at improving healthcare quality. With a cadre of former federal and state officials, Mercer brings unparalleled knowledge of how states can operate a high-quality Medicaid managed care program within the federal quality framework for managed care. We have supported state Medicaid agencies with projects including but not limited to:

- Planning and submitting waivers for approval.
- Drafting responses to questions posed by CMS on waiver renewals, rate certifications, managed care organization (MCO) contracts, etc.
- Training Medicaid agency staff on CMS requirements, for example, new MCO CFR requirements.

Tools and Data Systems to Support Analysis

Mercer's expertise as a full service consulting firm highlights the sophistication of our knowledge pertaining to Medicaid data and data systems. This includes expertise in the operation of state Medicaid Management Information Systems (MMIS), integration of vendor systems (i.e., managed care, dental, pharmacy benefit managers, transportation, etc.), and the impact delegated relationships, benefits coordination, and third-party liability have on the capture and control of critical claims and encounter information.

Mercer's experience includes projects in a number of relevant focus areas:

- Validating (completeness and accuracy) encounter and fee-for-service data.
- Developing actuarially sound capitation rates for various states' Medicaid programs for physical health, behavioral health (BH), and long-term care.
- Benchmarking data across state clients.
- Conducting utilization review, disease management, and case management.
- Calculating quality indicators.
- Conducting geospatial analysis and mapping to determine provider network adequacy.
- Creating dashboard reporting for the evaluation and assessment of health programs.

Our experience with technology, data, and information management provides the knowledge and insight critical to performing an Information Systems Capabilities Assessment (ISCA). Issues in system operations and data exchange often lead to increased claims rejections, poor encounter data submission, claims payment timeliness, and inaccuracies in performance measure (PM) calculations. Completeness and accuracy in each data element and step in data management is critical to accurate information and reporting. The Mercer team is exceptional at identifying opportunities for improvement in this area in MCO operations and providing technical assistance (TA) to vendors and clients.

Table: Proposed EQR Staff

Below are our proposed staff, areas of expertise, and experience related to all areas in the required Statement of Work (SOW). Additional information can be found in the staff bios on pages 27 – 51.

Name	Medicaid Beneficiaries	State & Federal Policy	Data Systems & Processes	Managed Care Delivery	Organizations	Financing	Quality Assessment & Improvement	Research Design	Methodology and Statistical Analysis
Jessica Osborne, BSW	X	X		X	X		X		
Lois Heffernan, MBA, RN, BSN	X	X		X	X		X		
Jennie Echols, PhD, MSN, RN, CPHQ	X	X		X	X		X	X	X
Jordan Bublik	X	X	X	X	X		X	X	
Laurie Klancher, MSN, RN, CRNP	X	X		X	X		X		
Laura Pavlecic, MBA, BSN, RN	X	X		X	X		X	x	
Rachel Henrichs	X			X					
Jennifer Lenz, QRS, MPH, CHCA (Subcontractor — QRS)	X	X	X				X		
Cindy Ward, MBA, BSN, RN	X	X		X	X	X	X		
Katherine Nichols, CPH, LCSW	X	X		X	X		X		
Jason Vogler, PhD, MA, BA, NADD-DDS, CSSBB	X	X		X	X		X	X	X
Elizabeth Collins, MSN, BS, BA, RN	X	X		X	X	X	X		
Laura Salkowe	X	X		X					
Scott Banken, MBA, CPA		X	X			X			
Brenda Jenney, PhD, MS, BS	X		X					X	X

Provide a summary of the staff' proposed for this project demonstrated experience and knowledge of managed care delivery systems, organizations, and financing. 42 CFR 438.354(b)(1)(ii), 42 CFR 438.356(b).

Managed Care Delivery Systems and Organizations

As a full-service Medicaid consulting firm, we believe our knowledge and understanding of managed care delivery systems and managed care plan operations are more advantageous to you than other External Quality Review Organizations (EQROs) that specialize primarily in EQR activities. We have over 35 years of experience helping states build and implement managed care programs from the ground up. Many of our team members are previous managed care executives, state Medicaid Agency staff, and CMS staff. As your EQRO, we provide a broader and deeper understanding of best-in-class Medicaid programs and Medicaid managed care delivery systems.

While Mercer brings this broad Medicaid experience, our team also has decades of EQR experience. Our comprehensive experience enriches managed care compliance reviews, as our team understands how managed care plans operate and can effectively evaluate all MCO operational areas — including care management, utilization management, member services, quality management, claims payment and encounter data submission, data and information systems, provider and network services, BH, and pharmacy. As demonstrated in the table below, Mercer's experience in managed care plan review extends well beyond EQRs, and we have supported a variety of MCO evaluations:

Examples	
Quality Service Review	Mercer implemented a quality service review (QSR) for persons with serious mental illness (SMI) to identify service strengths, service capacity gaps, and areas for improvement at the system-wide level for individuals with a SMI receiving services via the public BH delivery system in Maricopa County, Arizona. The QSR included an evaluation of nine targeted BH services: case management, peer support, family support, supported housing, living skills training, supported employment, crisis services, medication services, and assertive community treatment services.
MCO Comprehensive Operational Review	Mercer conducted a Comprehensive MCO Operational Review of a health plan in a northeastern state. The plan was reporting significant financial challenges that were not issues for other plans in the market. The review evaluated all aspects of local plan operations to identify instances where the plan was not operating efficiently and provided an array of recommended corrective actions to the MCO that allowed the MCO to continue to operate within that Medicaid program successfully.
MCO Readiness Reviews	In support of Medicaid managed care reprocurements, Mercer frequently conducts comprehensive MCO Readiness Reviews for incumbent and new plans that provide the state and CMS the information they need to ensure the MCOs are ready to begin operations and support members when a new contract period goes live.

Medicaid Financing

Mercer's team has extensive expertise with reviews of program integrity, focusing on reducing fraud, waste, and abuse. We have provided these services to over 30 different states. From an

EQR perspective, knowledge of healthcare financing is only a portion of what we bring to the table. Our EQR key staff understands the linkage between healthcare, financing, and delivery of healthcare quality.

As many Medicaid programs have focused system transformation efforts to incentivize value over volume, our EQR key team has been on the cutting edge of developing new and innovative approaches, working with states to develop value-based payment (VBP) models at both the provider and MCO levels. The proposed staff indicated in the table above on page 60 have state experience and knowledge related to managed care delivery systems, organizations, and financing that can support PRMP. For key personnel full bios, please reference pages 27 – 51.

Provide a summary of the staff' proposed for this project demonstrated experience and knowledge of quality assessment and improvement methods. 42 CFR 438.354(b)(1)(iii) 42 CFR 438.356(b).

As an experienced EQRO and consultant to states desiring MCO execution of best-in-class performance and improvement methods, Mercer has extensive knowledge and experience in applying quality assessment and performance improvement methods. We utilize the CMS Quality Framework, which incorporates both quality and performance improvement activities.

We recognize the priority of Puerto Rico's Quality Management Strategy (QMS) in establishing the structure through which quality and performance improvement activities occur. Mercer has assisted PRMP with the development of their QMS and appreciates PRMP's efforts to align Puerto Rico's QMS to the CMS and National Strategies. Our knowledge and collaboration on the QMS with PRMP serve as a foundation to build the EQR, MCO compliance, and quality improvement framework. Mercer seeks to support and collaborate with PRMP in delivering on the Triple Aim to "achieve better care for patients, better health for communities, and lower costs through improvement in the healthcare system."

We have implemented the following performance improvement techniques in many states, including Arizona, Delaware, Missouri, Pennsylvania, New Jersey, and New Mexico.

- **Driver Diagrams**: Driver diagrams offer a tool to show the relationship between the overall aim or goal for an initiative and primary and secondary drivers that contribute to achieving the aim or goal. The drivers assist with the identification of change ideas that can be implemented and tested to achieve the goal. Mercer has helped states and their MCOs in developing driver diagrams for guiding program improvement and evaluation projects.
- **Plan-Do-Study-Act (PDSA):** CMS and the Agency for Healthcare Research use this model for performance improvement. We routinely apply this model when conducting performance improvement projects (PIPs) or when providing TA to MCOs for conducting PIPs.
- **Rapid-cycle techniques**: While the PDSA model is meant to be used in a rapid-cycle environment, our experience working with states and MCOs is that Healthcare Effectiveness Data and Information Set (HEDIS®) measures are often selected, as they represent the "gold standard" for performance measurement and are a focus for CMS' Adult and Child Core Measure sets. However, it can take a year or more to determine whether a statistically significant improvement in a measure has been achieved. Therefore, we have encouraged states to use the concept of rapid-cycle "lead" and "lag" measures.

Lead measures are interim measures that determine whether interventions have a likelihood of success, while HEDIS represents the "lag" measure. Rapid-cycle approaches also set a window of three months during which interventions and follow-ups are performed; this keeps the concept of "continuous quality improvement" at the heart of all improvement efforts. This approach is just as effective when lag measures other than HEDIS are selected.

- **Compliance and Improvement Observation techniques:** Specific to our quality assurance work under our EQR and EQR-like engagements, our experience encompasses conducting managed care compliance and process reviews using the standard EQR protocol approach of requesting information, completing a desk review, and conducting on-site interviews. Additionally, our team has developed novel approaches for review, such as:
  - Tracer Methodology: This work modifies a proven technique used by The Joint Commission. Our tracers are built to examine a provider's or member's experience through the managed care matrix. Scenarios encompass complex, real life member and provider events. We present these scenarios directly to the front line staff at an MCO to gain a greater understanding of how systems integrate across the organization, the tools and training each staff member brings to the analysis and resolution of these situations, and the process used to track and trend activities for the purposes of quality assurance and performance improvement. We have used this approach in Delaware, New York, and Pennsylvania to help state staff and MCOs quickly identify missed opportunities for providing high quality member and provider services and areas requiring further training, education, and process streamlining.
  - Secret Shopper: Secret shopper approaches are invaluable for understanding what occurs on a day-to-day basis and for understanding the member's experience of working with a MCO. Secret shopper activities include performing an in-depth review of each MCO's public website and outreach to member services and provider services (including the member and provider call lines of any delegates or sub-contracted vendors). We have used this technique in Connecticut, Delaware, and New Jersey.
  - Member Journey Maps: Mercer has recently implemented a quality improvement process that involves leading MCOs in creating a member journey map that focuses on identifying the perspective of members and providers. Journey Mapping can also serve as a form of clinical audit that examines how the member's journey is managed at the point of initiation or identification for a program or services. The data provided by process mapping is used to redesign or improve the quality or efficiency of services experienced by the member along their journey to ultimately improve outcomes. Unlike a compliance audit that relies on adherence to documentation requirements through policy/procedure review and case record review, the Member Journey Map is an interactive process with the MCO.

We view our role as the EQRO as vital to Puerto Rico's drive toward quality improvement. This requires EQR staff experienced in a variety of quality improvement areas.

The proposed staff indicated in the table above on page 60 have state experience and knowledge related to managed care delivery systems, organizations, and financing that can support PRMP. For key personnel full bios, please reference pages 27 – 51.

Provide a summary of the staff' proposed for this projects demonstrated experience and knowledge of research design and methodology, including statistical analysis. 42 CFR 438.354(b)(1)(iv) 42 CFR 438.356(b).

Research design and methods, including statistical analysis.

Mercer staff bring years of research design, analysis, and reporting experience to the table. Our research projects range in scope from small to large focused studies and straightforward to very complex program evaluations. We provide expertise such as sampling and tool development, data mining algorithms, medical record abstraction databases, and performing statistical analyses using descriptive, inferential, and multivariate statistics. Our expertise has been applied to clinical and non-clinical areas and covers selecting, calculating, and validating HEDIS and non-HEDIS outcome and PMs, performing medical record abstraction, geospatial mapping to detect utilization and referral patterns, analyzing impact of pay-for-performance strategies, and a host of other quality of care and service studies.

Our key EQR team includes doctoral-level statisticians and healthcare researchers, licensed clinicians and pharmacists, healthcare data analysts, and informatics specialists with expertise in research design, data validation, measure calculation, statistical analysis, and report writing. We will collaborate with PRMP to present studies and findings with easy-to-interpret graphics and easy-to-read language so a broad range of audiences can benefit from the information. We specializing in making complex concepts accessible to a general audience.
Some examples of research and analytic projects we have conducted include:

- Acting as the Independent Evaluator for the St. Louis Regional Health Commission's Gateway to Better Health 1115 Demonstration Waiver.
- Completing a focused study of the State of Delaware's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) federal reporting processes, identifying best practices and opportunities in the State's EPSDT program data collection, monitoring, and reporting systems.
- Conducting an independent study for the State of Texas on reasons Medicaid members miss EPSDT check-ups and evaluating the effectiveness of five outreach strategies.
- Conducting a focused study on "Treatment Outcomes and Prescribing Patterns among Delaware Medicaid Managed Care Plans for Members Prescribed Buprenorphine." See Appendix E of our response.
- Analyzing geospatial positioning and utilization trends of primary and specialty providers to inform the State of Delaware's network adequacy standards.

Some research projects also incorporated qualitative data collection. Mercer's team includes consultants who have qualitative expertise and are experienced with analyzing member, provider, and stakeholder input. The proposed staff indicated in the table above on page 60 have state experience and knowledge related to managed care delivery systems, organizations, and financing that can support PRMP. For key personnel full bios, please reference on pages 27 – 51.

Provide a narrative that demonstrates that the EQRO have sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities. 42 CFR 438.354(b)(2) 42 CFR 438.356(b).

Mercer's qualifications as an EQRO extend beyond the standard competence and independence requirements outlined in 42 CFR 438.354 and fully meet the requirements of physical, technological, and financial resources to support this scope of work. The team supporting this work is part of Mercer's Government Health Care sector that provides comprehensive consulting services in all areas of Medicaid, Children's Health Insurance Program (CHIP), and human services program management, and has national experience in EQRs, actuarial rate-setting, healthcare informatics, and Medicaid program oversight. PRMP's EQR team is not only deeply experienced in EQR, it has the support of the most diverse interdisciplinary team of consultants in the market today, including nurses, physicians, licensed social workers, BH and substance use professionals, pharmacists, former CMS administrators, former State Medicaid leaders, actuaries, Certified Public Accountants, program integrity specialists, and dental professionals.

Mercer has the technical infrastructure to support this work. We have made substantial investments in commercially recognizable and globally supported technology and tools to provide for the intake, validation, storage, analysis, and reporting of large claims, encounter data sets, and PM data. Our data warehouse utilizes Oracle database management software. Our primary tools used to support the intake, validation, analysis, and reporting of PRMP's data will be industry-standard SAS software and PL/SQL software products. All of our data systems have up-to-date security and privacy features, with multiple layers of redundancy for maximum protection. Mercer's information technology (IT) system configuration provides for scalability and expansion of both server space and processing power, as needed, for data warehousing and other analytics. For disaster recovery and business resiliency purposes, our backup process allows for recoverability and business continuity, enabling stored data retrieval within hours. All application servers connect to each other and to the mass storage device with 10-gigabit fiber-optic network connections. We built and designed our platform to expand and easily scale to meet the needs of our clients.

In addition to our ability to securely intake and validate data, Mercer has the ability to accept medical records in compliance with the Health Insurance Portability and Accountability Act (HIPAA) standards, ensure HIPAA standards for data and document management will be met, and ensure that any protected health information (PHI) released is done so in accordance with HIPAA requirements. Mercer will establish a PRMP-specific File Transfer Protocol site if desired by PRMP.

Mercer is a subsidiary of Marsh McLennan, whose global revenues in 2020 were more than $17 billion. Our access to capital and financial strength are major advantages over our competitors. Mercer is a global consulting leader. Our stability is reflected in our roots, which can be traced back to 1945 when the Mercer name first appeared in Canada. That firm was acquired by Marsh McLennan Companies in 1959. Our business strategy has consistently included organic growth and the acquisition of firms that are leaders in key human resource

areas. Please see the Marsh McLennan annual report[1] for more details on the financials of Marsh McLennan and Mercer.

Provide a staffing summary plan which demonstrates that the EQRO have clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractor. 42 CFR 438.354(b)(3) 42 CFR 438.356(b)

Puerto Rico's core EQR team members include licensed clinical consultants and non-clinical health industry professionals who have worked with PRMP on other Medicaid projects and possess a unique breadth and depth of understanding of PRMP, as identified in the organization chart and proposed staffing hours referenced on pages 25—26. As noted in their bios, this team has decades of not just EQR experience, but quality improvement, managed care operations and oversight, and clinical and non-clinical healthcare expertise. In addition to the dedicated PRMP EQRO team that includes clinical, policy, information systems, finance, and statistics experts, Mercer's government practice provides access to actuaries, data analysts, and staff with other expertise to support PRMP as needed. Our team is qualified to conduct all EQR activities, including those that may require licensure, such as medical records reviews.

Each area of the EQRO Scope is assigned a lead subject matter expert (SME) who will be supported by a larger team as described in the organization chart (see page 25). QRS, our proposed subcontractor who will assist with performance measure validation (PMV) will also have a PRMP EQR project lead, Lois Heffernan, who will oversee the subcontract and monitor compliance with PRMP, EQRO, and Mercer protocols. The project is further supported by a team of strategic advisors who are always on hand to bring additional subject matter expertise or resources when they are needed. The strategic advisor team represents each sector within Mercer and offers a connection to the breadth of our entire company's experience.

Provide a narrative that illustrates the respondent's understanding of PRMP's requirement and project schedule.

We understand that PRMP has committed to local government, CMS, and Congress that there will be a robust assessment of the MCOs and validation of performance of all contractors. The initial scope provides a baseline for PRMP to demonstrate compliance to CMS and sets the stage for subsequent EQR activities that provide PRMP with the insight necessary to look beyond compliance and drive a high-functioning program that achieves the results the MCO members deserve. Mercer has a deep knowledge of the Medicaid delivery system in Puerto Rico and of the current MCOs' areas of strength and opportunities for improvement. We are ready to apply that knowledge by designing and performing an efficient and thorough compliance evaluation to meet the legislative requirements and agency goals.

Understanding the impact of all MCO requirements and translating the results of evaluations into improvement actions is what Mercer does best. Our proposed approach for accomplishing this work includes these key evaluation strategies:

- Planning for systematic and thorough information and data collection.

[1] http://irnews.mmc.com/phoenix.zhtml?c=113872&p=irol-reportsAnnual

- Furnishing the review tools to implement effective reviews.
- Providing TA to PRMP and the MCOs around the EQR process.
- Providing a team with the experience and skills necessary to complete this complex review project on time and on budget.

Submitting an EQR technical report to PRMP and CMS that clearly articulates methodology, findings, and assessment of impact to support future policy decisions and transition improvement opportunities.

Approaches to Transformation

Mercer is known for bringing an innovative approach to our work with our clients. Mercer views innovation as a continuum that runs from the incremental to the truly transformative. **Incremental improvement** involves a series of small innovations that take an existing process and increase its effectiveness, quality, or value. The other end of the continuum is characterized by total transformation — radical, sweeping change that impacts the entire system. Mercer is skilled at both ends of this continuum. Mercer has assisted our clients with incremental improvements, as well as with a more transformative vision of how to position EQR to maximize the value of an EQRO.

Incremental Change

Given that EQR activities eligible for enhanced match, both mandatory and optional, are determined by CMS through the EQR protocols, there are limits to the innovation the EQRO can offer while leveraging the enhanced match rate. However, **incremental improvements** in innovation should be viewed in the context of what an individual EQRO offers and the potential **synergies** that can be formed between PRMP and its EQRO partner. Mercer offers examples of how we have conducted prior work within the CMS requirements and used the EQRO contract as a funding mechanism to serve as a system-transforming agent in our relationship with the client.

Transformative Change

With nearly two decades of EQR experience, Mercer's vision of an effective EQR approach has evolved to encompass three different levels of service and integration. These three levels encompass Classic EQR, Value-Based EQR, and Integrated Purchaser EQR. Mercer is proposing the **Classic EQRO** for PRMP, addressing requirements in the Request for Proposal and allowing us to meet your specific needs at this time to achieve your QMS and other programmatic goals. Mercer strives to provide an evolutionary context for how an EQRO can be leveraged over time to help drive year-over-year improvements in your Medicaid managed care program. Mercer envisions the effective leveraging of an EQRO as one of the most critical tools in a state's tool belt to ensure a quality-based system of care. A description of each of the three levels, starting with the **Classic EQR** model we are proposing, and then describing our capability to grow with PRMP into a fully integrated EQR as desired by PRMP:

- **Classic EQR:** Initially in year 1, this approach to the fundamentals encompasses the CMS mandatory and optional EQR activities as requested by the Client, and layers in the incremental innovations, such as file reviews and focus studies. States often select which optional activities they wish to pursue based on budgetary and other program considerations. Classic EQR services are a good starting point or launch pad for states looking to build the competency of staff and managed care contractors to accomplish basic

quality management principles and goals and move toward more value-based models of care.

- **Value-Based EQR:** As states take on increasing complexity within their managed care program — such as introducing new populations, new integrated models like ACOs, or implementing alternative payment models (APMs) — the monitoring and oversight requirements increase, as does the tension to realize the value proposition of better outcomes for lower cost and improved member experience. As a result, the Medicaid agency approach to the EQRO should evolve as well, with the EQRO subtly shifting from being the state's quality consultant to the state's program consultant. This type of EQR service is more complex and requires higher-level knowledge of healthcare financing and policy implications.
- **Integrated Purchaser EQR:** As states enter into more complex payment arrangements, as legislative requirements emerge, and as new services are carved into managed care, states need an EQRO that can keep pace with the program's evolution. This often means the EQRO must work collaboratively with other state consultants, vendors, and contractors in the design and development of new enhancements to an existing managed care program. In some instances, the EQRO may work with the state's actuary to address components of network adequacy or to investigate concerns related to capitation. The EQRO holds detailed knowledge of the operations of contracted managed care entities. That knowledge can be leveraged when discussing the impact of program changes. The EQRO can even be leveraged to conduct readiness assessments of accountable care organizations or medical home providers or to add input when discussing administrative implications of contract language changes. Some examples of Integrated Purchaser EQR include the use of EQRO consultants who specialize in claims, encounters, and data warehousing during planning for changes to the state's MMIS, or including EQRO clinicians to help redesign contract standards around case management ratios or care coordination standards.

Mercer will provide the right people with the right skills and tools to perform a multidimensional review and evaluation of the impact of MCO operational performance and quality results. Our understanding of the requirements and approach for the EQR includes the following core activities:

- Planning and project management throughout the life of the project
- Activities to complete review of:
  - MCO compliance with contract, Puerto Rico, and CMS regulations
  - Information System Assessment
  - Validation
- PMs
- Performance improvement activities
- Network Adequacy
- Information requests
- Data requests and data collection
- Surveys and interviews
- Document and data analysis
- Iterative analysis based on additional data, feedback, and insight from prior report submission
- Reporting

Mercer's Approach to the Scope of Work

The entire EQRO scope of work is assigned to a dedicated EQRO project manager, who will implement Mercer's project management approach. The project manager will use proven tools to clarify expected results and confirm progress and scope against agreed-upon deliverables and the project plan. When issues arise, she will use our risk escalation processes to ensure

rapid resolution. Routine meetings with the PRMP EQR contract owner and the Mercer EQR project lead, Lois Heffernan, and project manager, Jordan Bublik, ensure clear channels of communication and rapid response to changing priorities. Underlying this process is collaborative decision-making to drive progress of the work plan, role clarification, articulation of project dependencies, timely project communication, and project documentation.

To ensure high-quality consulting and work products, all work performed by Mercer is subject to a strict quality control process. We have clear, professional standards regarding the process of "peer review" (quality control) at various steps in product development. Mercer believes peer review of professional work delivers the highest-quality service to our clients. We apply peer review from a number of perspectives, reviewing all work products for:

- Technical accuracy of all calculations.
- Consulting appropriateness to ensure soundness of the approach and that the appropriate issue or question has been completely addressed in a clear manner.
- Editorial correctness, including full incorporation of client feedback.
- Final look to ensure a professional work product appearance that meets client specifications.

Work Plan

Mercer will work with PRMP to complete the required retroactive reviews in the first year of the contract cycle. The graphic on the following pages is a high-level timeline for the activities called for in the SOW for contract years one and two, followed by a description of annual, quarterly, and ongoing activities.


Mercer Contract Year One
Mercer Contract Year 2
Calender Year 2022
Calender Year 2023
Calendar Year 2024
M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D
Client Kick Off
Review SOW
Data Source Identification
Project Management
Internal Team Meetings
Client Meetings
PRMP and MCO Training and Technical Support
Compliance Reviews
Develop Request for Information (RFI)
MCO Kick Off
Full Compliance Review Triple S
Full Compliance Review MMM
Full Compliance Review FMHP
Full Compliance Review Menonita
Compliance Review Molina
Full Compliance Review Humana (Medicare Only)
Full Compliance Review MCS (Medicare Only)
MCO Years 2017-2021
MCO Years 2021-2023
CAP Follow Up and Management (as needed)
Performance Measure Validation
PM Validation Triple S
PM Validation MMM
PM Validation FMHP
PM Validation Menonita
PM Validation Molina
PM Validation Humana (Medicare Only)
PM Validation MCS (Medicare Only)
MCO Years 2017-2021
MCO Years 2021-2022
MCO Years 2023-2024
MCO Years 2021-2022
MCO Years 2023-2024


Mercer Contract Year One
Mercer Contract Year 2
Calender Year 2022
Calender Year 2023
Calendar Year 2024
M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D
PIP/QIP Validation
PIP/QIP Validation Triple S
PIP/QIP Validation MMM
PIP Validation FMHP
PIP Validation Menonita
PIP Validation Molina
QIP Validation Humana (Medicare Only)
QIP Validation MCS (Medicare Only)
MCO Years 2017-2021
MCO Years 2022-2023
MCO Years 2023-2024
ISCA
ISCA Triple S
ISCA MMM
ISCA FMHP
ISCA Menonita
ISCA Molina
Network Validation
Network Validation Triple S
Network Validation MMM
Network Validation FMHP
Network Validation Menonita
Network Validation Molina
Report
Draft Final
Program Integrity Review
MCO Years 2021-2022

Annual Activities

Our annual compliance activities typically include request for information (RFI) development, desk review, on-site review, and report writing. Specific reviews conducted annually include:

- Full Compliance Review (full review required every three years with MCO corrective action plan [CAP] and follow-up review annually)
- PIP/Quality Improvement Project (QIP) Validation
- ISCA
- Network Validation
- Program Integrity Review (activities included in the Compliance Review)

The culmination of all annual EQR activities are the CMS Annual Technical Report, the EQRO Public Report, and the Managed Care Program Report. Data for these reports is collected throughout the year and the compilation of information typically takes about four weeks. A full compliance review will be conducted in Contract Year 1 to accommodate the gap in EQR reviews from 2017–2021, then the full compliance review will accommodate for the required every year three period with continued annual review of CAPs and follow-up. Validation of PIP/QIP, ISCA, network adequacy, and program integrity will result in an annual report, along with any optional activities PRMP elects to complete that occur once per year.

Quarterly and Ongoing Activities

The balance of the work plan is composed of activities that are ongoing (such as monthly meetings) or occur quarterly. For example, on a quarterly basis, Mercer will review quality PM reports and will attend quality improvement meetings with PRMP and MCOs

A truly effective EQRO will be able to not only help Puerto Rico measure MCO quality of performance, but also to translate that measurement into action. The ultimate goal of quality performance measurement is to answer **value-based questions**, such as:

- Are we getting the highest quality of care for our population for the funds being spent?
- Are the lives and health outcomes of the citizens we serve improved?
- Is the system of care functioning as efficiently and effectively as we envisioned?

Performance Measurement and Reporting

Mercer's EQR team has the necessary **experience developing technical specifications** for PMs based on Puerto Rico-specific needs. Our framework for performance measurement, as well as the PMs selected, is purposeful and drives actionable outcomes. Mercer can develop Puerto Rico-specific measures, as we have a deep **understanding of Puerto Rico's needs**, and your MCO's **data collection capabilities** (including authorization systems, claims processing, and encounter submission), and **data presentation** (i.e., data visualization).

Our team's **expertise in the use of nationally recognized PMs** from organizations such as the Agency for Healthcare Research and Quality (AHRQ), CMS, and National Committee for Quality Assurance (NCQA) is unmatched and is further supported by relationships between Mercer, CMS, and NCQA. Our team have expertise developing **PM frameworks**, managing **large data sets**, programming the technical specifications for PMs (including **HEDIS** and **Core Measure** specifications), and the ability to "slice and dice" data as needed to inform the state. Our ability to present data results in a visually appealing and understandable manner for

audiences ranging from the general public to legislators and CMS is critical to taking reporting into information that is actionable for your team.

Paradigm shift

In **Mercer's role as a trusted advisor** to the states where we provide EQR support, we often **aid the state in designing an approach to quality** that supports a **paradigm shift in which quality becomes woven throughout the agency.** Some examples of work that may fall naturally under an EQRO contract include:

- **Assistance with Puerto Rico's QMS:** As your EQRO, Mercer can help to calculate measures, analyze results, identify interventions, and provide TA to Puerto Rico to help close gaps in care or service in order to drive continuous quality improvement efforts. Additionally, the **EQRO can provide TA to Puerto Rico** to further align the QMS and other performance measurement and outcome activities, such as those contemplated in VBP models, which are becoming ubiquitous in Medicaid managed care programs.
- **Program Integrity Reviews of MCOs:** While EQROs are tasked with assessing the quality, access, and timeliness of services delivered, many of these areas have a direct relationship with program integrity activities. With Mercer, you are gaining an **EQRO with experience** in evaluating the quality of each MCO's program integrity program, which can help to further align activities across the full spectrum of MCO operations; this will serve to **break down silos within Puerto Rico** that may exist between departments, divisions, and sister agencies. Mercer achieves this because we have **right team,** with expertise in **finance, accounting, and program integrity** that can be critical to incorporating this type of review into the EQRO SOW. Mercer has staff with the expertise to serve Puerto Rico.
- **Assistance with Development and Implementation of VBP Models:** When states begin to introduce VBP and APMs, they are often decoupled from performance measurement contemplated in the state's QMS. To develop these types of programs requires a **strong knowledge** and **experience** in healthcare financing and how VBP program design can impact actuarial capitation rate-setting activities and assumptions, as well as consideration of how **program design** can impact different areas of managed care plan operations. Selecting an EQRO, such as Mercer, that has strong experience and understanding of these different and interconnected facets of program operation can benefit Puerto Rico as the program moves toward value-based models and alternative payment structures. Utilizing your EQRO as a key contributor in the development and refinement of these types of programs demonstrates how a state can leverage its EQRO, especially if Puerto Rico is interested in value-based or integrated purchaser EQR models.
- **Development of Monitoring and Oversight Tools.** While EQROs are prohibited from performing ongoing monitoring and oversight, Mercer can **provide TA**, project management support, and **technical resources** to assist Puerto Rico in developing/refining its monitoring and oversight approach, including the development and implementation of **new tools** and **dashboards**.

Describe the detailed process to be used for conducting and completing the MCO annual quality survey. Respondent will have to include the proposed data collection tool and the format to be used.

To meet the Medicaid Managed Care Regulations Assessment of Compliance, Mercer utilizes the CMS *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care*

Regulations (released by CMS on February 6, 2020) and Mercer's tools based on the Protocol Worksheets that support compliance review activities. Mercer has enhanced these foundational tools and improved functionality, utility, data display, and reporting.
To adhere to CMS protocol, Mercer will follow the basic "EQR Arrow" depicted below:

Mercer's approach to compliance reviews offers the experience of our team and identification of best practices and development of state-of-the-art tools to aid in the consistency, efficiency, and effectiveness of our approach. **This includes our electronic tool that houses a framework for all review areas and elements to be evaluated. Our tool also captures** findings of the desk review and on-site interviews and the reviewer assigns a compliance designation (i.e., met, minimally met, partially met, substantially met, not met). Our tool improves efficiency in report development and provides a historical database to compare year-over-year findings, recommendations, and corrective actions. Our established process and tool ensure you have full access to the valuable insights our individual SMEs bring.

Some Mercer clients prefer to be directly involved in review activities, while others prefer to have less direct participation. The following description of Mercer's approach is based on a moderate level of client participation in review activities.

In preparing for the annual compliance review, Mercer will facilitate a kick-off meeting with PRMP to discuss changes to program and contractual requirements. Mercer also considers information captured through various oversight methods and through ongoing collaboration with PRMP to identify specific issues of concern for the sections to be reviewed in the current review cycle.

The following activities describe the succession of steps for the ERQ process.

RFI

Mercer will develop a detailed RFI tailored to the MCOs being reviewed and the areas targeted for review and validation. Our experience has shown that including all organizational review areas in one RFI makes response and collection of the necessary information in a timely and efficient manner significantly less cumbersome for an MCO. The compliance RFI requests detailed information required to evaluate the targeted review areas.

Desk Review

Once Mercer has received the information requested through the RFI, we will begin the desk review process. Examples of our activities include:

- **Desk Level Evaluation** — Mercer will utilize our proprietary online tool to evaluate information submitted against defined standards and metrics consistent with Balanced Budget Act of 1997 requirements and modified to include any PRMP-specific requirements.

Our SME in each area will complete the desk-level evaluation; once the evaluation is complete, **our EQR team will meet internally to review findings and identify items of concern requiring cross-collaboration and follow up with PRMP and/or the MCO.** For example, our grievance and appeal SME may discuss concerns around the number of imaging appeals withdrawn with the utilization management SME to understand the review process. This may result in additional discussion with the SME reviewing delegation oversight, as imaging is often a delegated service. Through these discussions, they may identify the need to ask additional questions on-site about how appeal decisions are documented and denial letters issued to ensure consistency in appeal management and processing.

At the conclusion of the desk review, our team will be fully prepared and have developed on-site interview questions, which we will share with our PRMP partners. Prior to the on-site review, **our team will meet with PRMP staff to present preliminary findings and discuss concerns or areas of emphasis that may be required during the on-site review. This allows for collaboration and deeper understanding between the Mercer EQR team and PRMP.**

- **Medical Record/File Reviews** — Mercer will work with PRMP to identify the appropriate types of files for review, such as: care and case management, provider credentialing, provider termination, and appeals and grievance. **Mercer has found that file reviews in these areas provide significant insight into the operational compliance with managed care and contract standards and requirements.** Mercer leverages NCQA's 8/30 rule as the foundation for evaluation of healthcare organization file reviews. The rule states that of a sample of 30 files, if the initial eight pass the review, the entire sample of 30 can be cleared. The additional 22 files will be reviewed if issues are discovered in the first eight. The NCQA has evaluated this method to be "a cost effective and statistically appropriate method of gathering data about the overall performance" of a healthcare organization. In an effort to be efficient, yet comprehensive in our medical record file reviews, Mercer employs a variant of the 8/30 rule, and chooses to review 10 files selected from a sample of 30. For file reviews in which there is not enough volume to reach the minimum files for review, Mercer reviews all files submitted by the MCO for that category.

On-site Activities

Mercer has found that a cross-functional team of reviewers with a strong understanding of each functional area greatly enhances the review process, as well as the resulting recommendations. We will coordinate our review teams to be accompanied by appropriate PRMP staff responsible for MCO oversight and monitoring. The review will begin with a combined introduction with appropriate vendor staff, after which the interviews with identified staff will begin. Staff interviews are conducted during the on-site reviews to assess the compliance, accuracy, and efficiency of clinical management, operational management, financial reporting, claims processing, and program integrity operations of the MCOs and adherence to state, federal, and contract requirements.

Transferring knowledge and enhancing state staff skills are often a part of a state's ongoing oversight and monitoring goals. Mercer welcomes the involvement of PRMP staff in the desk review and interview process. To this end, from our proprietary online tool,

Mercer generates an interview guide (MS Word or Excel) that details the metric being evaluated, the information documented from the MCO submission, and the on-site questions. We will begin the on-site review with introductions and an explanation of the purpose of the review. We will also provide the vendor an opportunity to highlight accomplishments and challenges during the previous year. Afterward, the interviewers will break off into different tracks and interview vendor staff as validation of the desk review material. We conduct interviews in groups with each vendor's cross-functional staff member representation, as appropriate, so we can gather information in an efficient manner for all participants. We focus the interview so the knowledge we gain supplements and verifies what we learned during the desk review.

At the on-site review, Mercer will team up with PRMP staff to perform the MCO staff interviews to assess compliance in day-to-day operations. Mercer and PRMP staff interview the MCO operational staff to determine the effectiveness of the administrative functions, including provider contracting, member services, utilization management, medical directors, case management, resource and care coordination, reporting, compliance, and program integrity to assess compliance, efficiency, and accuracy, and to complete an overall assessment of business operations.

During the on-site portion of the review, **Mercer has leveraged the innovative use of tracer scenarios as part of the PRMP EQR to examine a provider's or member's experience through a complex system.** This work builds upon a proven technique used by The Joint Commission. Our EQR Core Team develops these scenarios to encompass multi-faceted, real life member and provider scenarios. These scenarios are presented directly to the front line staff — as opposed to management or senior level staff — at the MCO to gain a greater understanding of how systems coordinate across the organization, the tools and training each staff member brings to the scenario's resolution, and the process used to track and trend activities. This approach has assisted in quickly identifying missed opportunities for providing high quality member and provider services, as well as areas requiring enhanced training, education, and process streamlining.

Mercer will close the on-site review with an exit conference to give high-level feedback on findings, address issues that remain open, and lay out the timeline for the report and next steps. While Mercer understands that formal corrective action may be required, **Mercer leverages the site visit and exit conference to present review findings as opportunities to collaborate with PRMP and other system stakeholders towards continuous improvement of the system of care.** At times, the on-site review identifies gaps in materials submitted by the MCO to demonstrate compliance. Mercer may request these materials be submitted immediately following the on-site review to finalize the evaluation against requirements.

Analysis

Following the on-site reviews, Mercer will evaluate any additional follow-up information submitted. We will also assess any previously minimally met, partially met, substantially met, or not met items from the desk review and issue a final score for each metric. Analysis of findings from the desk review and on-site reviews is conducted as scoring is finalized and a narrative will be developed identifying strengths and opportunities. This final scoring will feed

the technical reports and allows for comparisons across MCOs and the identification of strengths and opportunities for each entity. Mercer's experienced quality professionals will conduct assessments and analysis to provide PRMP with a rich understanding of the Puerto Rico Medicaid program and quality tools and processes to maximize improvement plans. The narrative comments from the analysis, provide a summary of findings, opportunities for improvement, and CAPs required.

Technical Report and CAPs

The last portion of the post-on-site activity is the technical report. Mercer will develop an MCO-specific summary report containing the strengths, opportunities, methodology, metric-specific findings, and individual recommendations. After PRMP and the MCO approve the report (for errors and omissions only), Mercer will issue the report and the request for the CAP to the MCO. Each MCO-specific summary report is constructed in order to allow easy integration of information into the Annual Technical Report required by CMS.

Provide a redacted copy of a completed annual quality review of a Medicaid MCO and the corresponding executive summary demonstrating how the respondent designed and implemented a tool capturing all Centers for Medicare & Medicaid Services (CMS) requirements. The sample provided must use a survey tool developed by the EQRO in house staff.

Mercer uses the proprietary online tool our in-house EQR staff developed to evaluate information submitted against defined standards and metrics that are consistent with Final Rule requirements and modified to include any PRMP-specific requirements. As the team completes the desk review, on-site review, and post-on-site analysis, we enter information into the online tool. The online tool has functionality to generate tables that are inserted into the appropriate section of the MCO report. As you will see in the example in Appendix C of our response, the report provides context for the area of evaluation, the sources of information (i.e., MCO staff who were interviewed), the metric for evaluation, a compliance score (e.g., Met, Substantially Met, etc.), a finding, and a recommendation. The report also included the standard tables for validation of PMs and validation of PIPs per the CMS protocols. We compile strengths and opportunities from each of the review areas and provide them in a summary format so readers can easily see areas where the MCO is performing above expectation and where they have gaps and room for improvement. Our clients and their executive leadership team have found these reports of great value as they leverage the information in them to inform the legislature and public on MCO performance.

Describe the data collection tool and the reporting format the proposer would use for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) annual evaluation report. Include sample tools and reports for review.

As outlined in 42 CFR 441, Subpart B, Medicaid programs have a unique responsibility to promote health, wellness, preventative care, and medically necessary care for children; this responsibility is recognized by the EPSDT benefit requirements for all Medicaid programs. PRMP and the Administración de Seguros de Salud (ASES) recognize the importance of EPSDT services and require all of Puerto Rico's Medicaid MCOs to ensure members have access to EPSDT services, educate members on this benefit, and conduct an administrative

PIP related to improving EPSDT rates. Mercer will provide an annual evaluation of MCO compliance with EPSDT requirements, including:

- Outreach and informing strategies
- Processes to ensure access to EPSDT services
- Provider education regarding EPSDT
- Requirements and billing procedures
- EPSDT performance rates.

Mercer will present a reporting format that will address findings for these EPSDT review topics ensuring the data collection and report will meet the needs of PRMP.

Further, as part of the PIP validation EQR protocol Mercer will conduct EPSDT PIP evaluations and provide MCOs with TA to ensure these PIPs are actively improving EPSDT rates and identifying opportunities to improve the EPSDT required PIP.

Mercer EPSDT Experience

Mercer's experience in supporting states' efforts to improve EPSDT goes beyond the evaluation of EPSDT federal requirements and includes detailed evaluations into the reasons a state has lower than desired EPSDT rates. For example, EPSDT rates are adversely impacted when providers lack understanding of how to properly code an EPSDT visit, which leads to lower EPSDT rates. We also understand that EPSDT is more than just screening for developmental delays; robust and frequent provider education on the treatment aspect of EPSDT is critical to ensuring children with delays obtain the care they need to address developmental delays. Mercer works with our clients to truly understand what is driving EPSDT rates and barriers to care and develop a plan with the state's MCOs to improve rates. We have conducted focused studies (an EQR Optional Task) designed to identify barriers and improve EPSDT rates and EPSDT reporting via the CMS-416 mandated reporting. Below is one example of work we have completed regarding EPSDT improvements:

Delaware: EPSDT Screening, Diagnostic, and Treatment Focus Study
To better understand the extent to which the State of Delaware's EPSDT program was meeting the needs of children and the federal reporting requirements, Mercer completed a focused study of its EPSDT processes. The purpose of the EPSDT focus study was to identify best practices and opportunities for improvement. The study helped the State develop requirements and interventions that targeted improvements in EPSDT rates.

Describe the data collection tool and the reporting format the respondent would assess network adequacy and delivery of health benefits in accordance with each MCO contractor risk agreement, please include a sample.

CMS has yet to publish the EQR protocol for Validation of Network Adequacy; however, when the new protocol is published, Mercer will adopt it and adapt our network validation approach accordingly. Our network adequacy validation team incorporates an interdisciplinary team of professionals with:

- Relevant local and national experience.
- Insight into and direct experience with Puerto Rico's Medicaid program, the geographical challenges, and the impact of the loss of physicians and other health providers.

- Experience in analyzing access to and availability of services.
- Experience with healthcare network design and MCO geospatial access reporting, including BH providers and services.
- Clinical understanding of the importance of including access to specialty providers, including substance use providers and other critical access providers.

For over a decade, Mercer has been engaged with developing strategies to evaluate network adequacy, accumulated extensive national experience assisting state and county clients to develop network time and distance standards, completed geospatial mapping to support network adequacy validations, performed service needs assessments, identified primary and specialty care referral patterns, and conducted “hot spotting” analyses. Our experience in developing network adequacy standards and network validation has varied widely across our clients, from basic geospatial coding to more complex, multi-pronged analyses that include surveys, focus group interviews, and analyses of utilization data.

Mercer’s data collection strategies used for network validation include:

1. **Assess data integration and control of provider data:** The Mercer team evaluates the MCO’s provider data management activities and systems. This evaluation includes an assessment of how the MCO’s systems and processes relate to the quality and accuracy of provider network information. If the MCO has delegated network arrangements, Mercer reviews the frequency of delegate network data submission(s) and the internal quality controls the MCO has in place to evaluate information and reporting received from their subcontractors and delegates.
2. **Review the production of geospatial and other required reports:** Mercer conducts an on-site review of each MCO to further evaluate the mechanisms in place to monitor and oversee the provider network, including the network of any delegated entities (for example APS Healthcare for MCOs who contract with this vendor for BH services). This may include a system demonstration, review of processes to validate provider accuracy, review of geographical access reporting, MCO validation of appointment availability, and disability access. The purpose of the on-site review is to fully understand how MCOs ensure network adequacy standards are met, oversee any subcontractor network adequacy, and validate information is accurately reported.

CMS signaled its intent to align Medicaid network adequacy standards with those in other insurance products with the issuance of 42 CFR Part 447.203 “Medicaid Program; Methods for Assuring Access to Covered Medicaid Services” and the subsequent Managed Care Final Rule released in May 2016 (with recently proposed rule changes issued in November 2018). Through these rules and related regulatory guidance, CMS provided a stronger framework and a modernized approach to help states establish and monitor network adequacy requirements across Medicaid delivery models.

Specific to Medicaid managed care, CMS has enhanced requirements related to network adequacy, including considerations for capitation rate development, enhanced state responsibilities for the development of adequacy standards, stronger state monitoring and oversight requirements, and the role of the EQRO in network adequacy validation. Before the publication of these enhanced requirements, **Mercer was attuned to the importance of network adequacy. For more than 10 years we have led various network adequacy**

assessments and assisted Puerto Rico and other Medicaid agencies with each of the requirements listed above.

In 2021, Mercer performed a network adequacy analysis and prepared a report of the PRMP for ASES. The main objectives of the analysis included identifying members' healthcare needs as a result of changes in plan membership, identifying current network strengths and gaps, providing recommendations for improvement of current network adequacy standards based on the identified needs and gaps, and developing interventions to address network gaps. To complete these objectives, Mercer used a comprehensive methodology to systematically identify key stakeholders, community partners, and available data sources to assess the current landscape of the system and its members.

Mercer utilized a five-phase approach to complete the analysis:

- Review of the Current Network Reports
- MCO RFI
- Desk Review
- Stakeholder Interviews
- Analysis and Reporting

Through an RFI, Mercer gathered available reports from the MCOs to assess current coverage, number of providers, available provider types, and membership composition. The RFI covered topics such as provider engagement and retention, integrated care, care management, payment incentives, telehealth, and cross-system collaboration. We reviewed member and provider survey results to better understand the member and provider perception of the system and the value, quality, and delivery of care. Mercer assessed the current state of health equity, disparities, and SDOH within Puerto Rico to develop meaningful, actionable, and effective recommendations. Upon reviewing all the collected information, Mercer used a "Met/Not Met" scoring rubric to evaluate the current network's compliance with standards such as time and distance, availability of appointments, and care management. From there, we assessed gaps and needs, performed additional supporting research of national best practices, and developed recommendations and potential interventions. Each recommendation and corresponding intervention was rated on its potential impact to the process and the effort and resources needed to implement the intervention.

Provide a detailed description of the process the respondent would use to validate the accuracy of the provider-related information submitted by each MCO, if possible, submit tools and report format that would be used for this project.

In the absence of CMS' Final protocol, Mercer has put forth a rigorous approach to validate the accuracy of provider-related information submitted by MCOs. As an important aspect of evaluating network adequacy, Mercer's process is to validate the accuracy of the provider-related information submitted by each MCO with processes that include:

- Provider network data request: In addition to requesting data to evaluate network adequacy, we will request information on processes that confirm credentialing processes and systems to update and communicate provider network access to members.
- With approval of PRMP, Mercer will review MCO online posted provider directories providing the data source for a Mystery Secret Shopper survey. This analysis examines the information contained in provider directories for network providers, including hours of operation, languages spoken, services provided, and whether the practice is accepting new patients. To further validate network and provider directory information, Mercer can perform

mystery shopper surveys to verify provider availability, members' ability to access appointments, the accuracy of the information in provider directories, the ability of staff to handle languages other than English, and after-hours processes, including provider and facility availability and response times. The Mystery Shopper Surveys generally include:

- Confirmation of provider contact information in the directory (e.g., address, telephone number).
- Accuracy of the provider listing (e.g., Is the provider still at the listed location and still participating in the plan?).
- Willingness to accept new referrals and evaluation of the percentage of providers who are taking new patients.
- Determination of earliest available date for a routine appointment to determine if getting appointments at specialist providers (e.g., child psychiatrists, substance use treatment, child sick and wellness visits, maternity care) is challenging.
- Prerequisites for scheduling an appointment, if any (e.g., requiring an ID card before an appointment can be discussed, requiring medical records, refusing to accept certain BH conditions).

Prior to initiating the provider accuracy report, Mercer will submit a draft survey tool to PRMP and confirm with PRMP the desired reporting format for approval. After completing the survey, we will present results to PRMP with recommended remediation plans for each MCO.

Provide examples of technical assistance that would be offered to both the MCOs and PRMP staff. Also provide explanation of how the need for technical assistance would be assessed.

Functionally, TA is woven into everything we do and is built into how we manage our EQR projects. Our team also views knowledge sharing as key to doing our job well and will be providing TA in all of our meetings with the PRMP team. Our EQR and large project management expertise enables us to track to a work plan and incorporate TA throughout the process. Mercer recommends establishing a regular schedule of meetings, which will occur at least weekly in the first months of the project, with a core team of PRMP staff for planning, project management, and implementation support. These meetings will be conducted by conference call or in-person if travel is permitted after the public health emergency. These regular meetings will provide the opportunity to identify areas of TA need and develop a comprehensive TA plan for both PRMP and your MCOs.

Additionally, Mercer encourages the participation of PRMP staff in the EQR on-site reviews. These sessions with MCOs provide PRMP with insight into MCO operations and opportunities for improvement, as well as providing PRMP with detailed information on the EQR process. Our state clients have found these on-site experiences invaluable in building a robust understanding of quality and performance improvement opportunities that exist within the program and how the EQR process works.

TA with EQR Process and EQR Findings and Recommendations

Mercer views TA as a core function of our work, particularly because open sharing of information ensures we are aligned in purpose with PRMP and builds the kind of rapport that makes the client-consultant relationship a true partnership. The role of the EQRO as an independent evaluator lends itself to TA, both in sharing how the EQR process works and how

we conduct our reviews, but also in the results of the reviews, which provide PRMP with the information you need to understand how your MCOs are performing and how well the program overall is achieving your QMS goals. We will provide TA as a normal course of business through our recurring meetings with PRMP, as well as through formal TA sessions for the PRMP team on topic areas identified during the course of our engagement. Our goal is to ensure the PRMP team members become SMEs in the EQR process and gain a deeper understanding of how your MCOs are performing and whether the program overall is achieving PRMP's QMS goals.

Our work plan includes key kick-off and recurring meetings with the PRMP team to solicit feedback on the annual work plan, timelines, milestones, and deliverables. During these meetings, our team will routinely educate PRMP staff on the EQR requirements and how those requirements are woven into Mercer's review process. Our team understands the required timing for key PRMP deliverables to CMS, such as the annual EQR technical report and annual Quality Management Evaluations, and will ensure PRMP staff are aware of those timelines and that our deliverables are provided to PRMP in advance of those deadlines.

TA to MCOs

Mercer has found clear communication with MCOs vastly improves the quality of the EQR and reduces anxiety and confusion for all parties. Therefore, our work plan includes the following planned TA sessions with the MCOs:

- In advance of the release of the EQR RFI: We will conduct this session releasing any RFI to ensure we review it in detail with the MCOs and they have an understanding of the documents requested, how and where to submit requested materials, timelines, and due dates. MCOs will also have an opportunity to ask questions about the process.
- In advance of the On-site Review: We will hold this session prior to the Mercer and PRMP team's on-site review with the MCOs and will share the on-site agenda, ensure the MCO knows the staff who must be present during the on-site reviews, any presentations or demonstrations they may need to prepare (for example, the EQR team may request a demonstration of the MCO's care management platform or wish to sit in on member services calls), and overall expectations of the on-site portion of the review.
- After the EQR: We will provide a review of the recommendations or corrective actions identified during the review.

TA Beyond EQR

Our EQR team has broad national Medicaid experience and includes former CMS administrators who are experts in Medicaid policy, which means we bring more than just the ability to provide TA on EQR protocols and quality improvement. We can assist in virtually any area of Medicaid program management and have a vast understanding of how other Medicaid programs operate nationally, allowing our team to provide TA beyond the ERO process and managed care oversight. Some highlights include:

- **TA with PRMP's Program Oversight Strategy:** While EQROs are prohibited from performing ongoing monitoring and oversight, as your EQRO, Mercer can **provide TA**, project management support, and **technical resources** to assist Puerto Rico in developing/refining its monitoring and program oversight, including the development and implementation of **new tools** and **dashboards**.

- **TA with Puerto Rico's QMS:** As your EQRO, Mercer can calculate measures, analyze results, identify interventions, and provide TA to PRMP to help close gaps in care or service to drive continuous quality improvement efforts that go beyond the EQR review. We can also provide **TA to your team** to align the QMS and other performance measurement and outcome activities, particularly if the program desires to include VBP models, which are frequently employed in Medicaid managed care programs nationally. Mercer has found that as MCOs implement APMs, there is a need for TA on topics such as design of the APMs, measures used, development of technical specifications, and reporting mechanisms, benchmarks, and performance thresholds.

Provide sample of a comparative analysis the respondent has completed on Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, or other similar data.

Mercer has provided a sample comparative analysis in Appendix D.

Describe the respondent's process for validation of each MCO's performance improvement projects. Include proposed reporting format and protocols used.

The Value of PIPs

PIPs are an important tool MCOs use to improve the health and outcomes of their populations, improve their processes, and address provider and member satisfaction with their health plan. Unfortunately, many MCOs only implement state-mandated PIPs, versus using the PIP process broadly whenever an issue is identified in order to continuously improve the MCO's clinical outcomes and operational processes. Even when their contracts require PIPs, MCOs may have limited focus and resourcing, quality staff turnover, lack of reliable data, and poor cross-MCO collaboration, which result in PIPs with little to no meaningful improvements, or outcomes that cannot be evaluated for effectiveness because of issues with the study question, collection of the data, and overall analysis of data. Oversight, evaluation, and TA are vital to developing PIPs that address areas desired by PRMP, are built with solid PIP design, and make actual improvements to the Plan Vital program.

Our goal as your EQRO is to bring focus and rigor to PIPs as a powerful improvement tool, and to move from PIPs that produce little real improvements to PIPs designed to produce meaningful and sustained improvements that ultimately improve the health of Plan Vital members. Mercer's team consists of quality improvement professionals with a passion for not only evaluating PIPs as part of the EQR protocols, but also in assisting states to identify performance improvement opportunities in a variety of areas, including acute care, BH, LTSS, developmental disabilities, and children and youth with special needs. Mercer uses CMS *Protocol 1: Validation of Performance Improvement Projects* (released by CMS on February 6, 2020) to validate MCO PIP activities and CMS *Protocol 8: Implementation of Additional Performance Improvement Projects* (released by CMS on February 6, 2020) to assist PRMP to design and implement PIPs with a solid design framework and to support this work with in-depth TA to both PRMP and the MCOs.

Our PIP validation approach includes the following:

RFI and Desk Review

Define Validation Scope

The Mercer PIP team leads will meet with PRMP to discuss which PIPs should be selected for validation. We understand that by Plan Vital MCO contracts, PRMP requires the MCOs to have a minimum of five PIPs:

- One clinical care project in the area of increasing fistula use for enrollees at risk for dialysis.
- One clinical care project in the area of BH.
- One administrative project in the area of EPSDT screening.
- One administrative project in the area of reverse co-location and co-location of Physical and Behavioral Health and their integration.
- One additional PIP as specified by ASES.

Issue RFI

Once we have an understanding of the PIP reporting document, we address which data elements may be required for validation. From this conversation, we build our RFI. We may request documents such as those listed below as part of the RFI:

- PM specifications, including detail of the numerator and denominator.
- Eligible population.
- Underlying research.
- Methodology and reasoning for selecting certain benchmarks or performance improvement thresholds.
- Tools used to support barrier analysis (for example, Pareto charts, fishbone diagrams) and the results of such analysis.
- Approach to selecting interventions (for example, four-quadrant grid, cost-benefit analysis).
- Mechanisms and forums in place to monitor progress and ensure rapid-cycle process improvement.
- Short, written responses to specific questions outlining the MCOs' approach to PIPs.

We will work with PRMP to adjust our RFI based on whether selected PIPs are in an initial versus a re-measurement phase. The focus of the RFI between initial baseline validation and subsequent re-measurement years is different, as many of the foundational elements of the PIP validation worksheet do not need to be revalidated in subsequent years unless changes to the study questions or study measures occur.

Perform Detailed Review of Submitted Documentation

Using the Mercer PIP validation worksheet, our PIP lead, healthcare analyst, and statistician (as needed) begin the review process. The following elements demonstrate the types of validation activities and criteria we will use to complete the review:

- **Clear definition of the study question(s):** We examine the study questions to verify they are simple, clearly stated, and adequately structured to enable the researchers to maintain the focus of the PIP and set the appropriate framework for data collection, analysis, and interpretation.
- **Accurate definition and integrity of selected study indicators:** Mercer ensures the study indicators (quantitative or qualitative) used for tracking performance and improvement in the PIPs are relevant, objective, measurable, clearly and unambiguously defined, and based on current clinical knowledge or health services research.

- **Adequacy of the identified study population:** The reviewers validate that measurement and improvement efforts are targeted to the entire Medicaid enrolled population to which the PIP study indicators apply and ensure this entire population is correctly identified**.**
- **Sampling methods:** Mercer verifies that the sampling methodology is statistically valid and reliable and that the results obtained through sampling can be generalized to the entire study population. In general, Mercer seeks to ensure a 95% level of confidence. Mercer validates that all the assumptions made in arriving at the sample are reasonable.
- **Completeness of the data collection tools and procedures:** Mercer ensures a sound and comprehensive data collection plan was used for the studies, including:
  - Clear identification of the data to be collected.
  - Identification of the data sources and how and when the baseline and repeat indicator data were collected.
  - Appropriate tool use for gathering data.
  - Specification of who collected the data.
- **Data validation:** When data has been collected from automated data systems, Mercer validates that specifications for automated retrieval of the data were devised and appropriately used. If data was obtained from visual inspection of medical records or other primary source documents, Mercer ensures the researchers selected the right number of medical records, established clear guidelines, provided staff education for obtaining and recording data, and used appropriate methods for ensuring data accuracy and reliability.
- **Thoroughness of data analysis and adequacy of interpretation of study results:** Mercer conducts a thorough review of the calculated performance on the selected clinical and non-clinical indicators. The review examines the appropriateness of, and adherence to, the statistical analysis techniques defined in the data analysis plan and the addressing of factors that threaten the internal or external validity of the findings.
- **Assess whether improvements are real and that sustained improvement is documented:** Mercer reviews the results and improvement strategies to verify that any of the stated improvements are a result of valid and sustainable changes in the processes of healthcare delivery. Such changes should result in sustained improvements and not be “one-time” improvements resulting from unplanned accidental occurrences or random chance.
- **Assess improvement strategies:** Mercer evaluates that any documented improvements in performance are clearly linked to a continuous cycle of measuring and analyzing performance and the development and implementation of system-wide improvements in care. If repeat measures of performance indicate that the quality improvement initiatives were not successful (that is, did not achieve significant improvement), Mercer ensures a valid and appropriate problem-solving process was performed (with data analysis when possible), root causes were identified, action plans were developed, and solutions were implemented. If the interventions were successful, Mercer verifies that the new processes have been appropriately standardized and monitored.

On-Site Interviews and Analysis

Assess MCO PIP Management Approach

The PIP lead works with the healthcare analyst to evaluate each MCO’s approach to PIP management. This evaluation includes a review of the staff involved in PIP development and implementation activities and the general approach and processes used to conduct research,

develop benchmarks and thresholds, select measures, complete barrier analysis, and select interventions to address identified barriers to success. The evaluation intends to ascertain whether the MCO has allocated appropriate numbers of staff with the requisite subject matter expertise and training and provided access to appropriate tools and resources, including a budget, to ensure PIP activities have a high probability of meeting or exceeding established goals.

Preliminary Findings and Outstanding Items

During the PIP's first implementation year, there is a subset of elements within the PIP validation worksheet that focus on the quality of the PIPs framework and structure. For a first implementation year PIP review, Mercer, through the validation worksheet, focus on assessing the study methodology, where we review the study topic, the population included, and the study questions. We review sampling methods and the collection procedures to ensure methods are clearly defined. Once these implementation year elements are evaluated and approved, they are not re-reviewed in subsequent re-measurement years as these elements of the PIP do not change. During the re-measurement years, Mercer focuses on evaluation of the MCOs' data analysis and interpretation, verification that appropriate tools were used to review the results to ultimately determine if statistically significant improvements are evident. After the MCO on-site interview, Mercer provides a preliminary assessment of the PIP's validity. The PIP lead requests any outstanding documentation and provides a timeline for submission to the MCO so the team can review these final items before developing the preliminary validation assessment.

Reporting

Determine Preliminary Validation Findings for Each PIP

Following the analysis of all available information, the Mercer PIP team lead develops a preliminary validation assessment. The MCOs have the opportunity to review the assessment and identify errors or omissions in the assessment and, as needed, provide additional documentation to support a recommended correction.

PIP validation requires several levels of scoring and includes the individual elements of each PIP, such as the evaluation of the study question or review of selected indicators, as well as overall PIP confidence in reporting results, success, and sustainability. Mercer scores individual PIP elements using a three-point scale (met, partially met, and not met) and an option for not applicable. However, we score the individual PIP elements, we review the totality of the PIP from approach to outcomes, and we score two key elements: "Confidence in Reported Results" and "Confidence in Success and Sustainability of Improvement Efforts."

Submission of Validation Report to Puerto Rico

Once all the necessary data is collected and reviewed, Mercer will provide a report that outlines each of the areas of review and the extent to which the MCOs have met each element. Per CMS guidance, information on the PIP validation will be presented using the Protocol 1 Worksheet 1.1 "Framework for Summarizing Information about PIPs." This worksheet includes the following:

- General PIP Information
- Improvement Strategies or Interventions (Changes tested in the PIP)

- PMs and Results
- PIP Validation Information

The detailed PIP results, as described above, will be shared with each MCO, and analysis in a distilled format will appear in the Annual Technical Report. The MCOs are required to develop a CAP to address all of the findings from the PIP validation. The Mercer PIP lead reviews the CAP and, as needed, will meet with the MCOs to ensure each entity's CAP approach results in improved compliance results in subsequent validation.

MERCER IN ACTION
MCO PIP Training for Delaware Division of Medicaid & Medical Assistance

Designed and Provided MCO PIP Training Mercer designed a detailed PIP MCO training for the Delaware Division of Medicaid & Medical Assistance (DMMA) that covered the PIP EQR protocol standards, how to develop an effective and measurable study question, a selection of available and appropriate PIP measures, and rapid-cycle improvement techniques, selecting both lead and lag measures. All presentation materials were shared with MCOs for use as a Train the Trainer tool they could use with their internal staff.

Evaluation of DMMA-Mandated Oral Health PIP
After the training, MCOs developed their mandated oral health PIPs. While the study question was the same for each MCO, interventions, measures, data sources, and lead and lag measures were selected by each MCO. Each MCO submitted their oral health PIPs to Mercer for evaluation, feedback, and, if they met DMMA's standards, DMMA approval.

Designed and Provided MCO PIP Training Session 2
To support the successful development of all required PIPs, Mercer developed a second MCO training focused on the EQR PIP Protocol evaluation standards. The session covered, in detail, the PIP Review Worksheet used by Mercer when conducting the annual formal EQR PIP evaluations. The goal was to ensure MCOs were fully versed in how the tool is used to evaluate their PIPs and how to use the tool internally to self-evaluate performance and areas of opportunity before the formal EQR PIP evaluations.

Evaluation of DMMA-Mandated BH PIP
After the MCO PIP Training Session 2, MCOs were to evaluate their required BH topic PIP against the PIP evaluation worksheet and submit their self-evaluation to Mercer and DMMA for review, feedback, and evaluation. Feedback was provided to each MCO in separate debrief sessions.

Provide a redacted copy of an EQRO Technical Report that was prepared by the respondent.

Included in Appendix C is the Delaware Technical Report as an example.

Describe how the respondent will fulfill the CMS requirement for validation of MCO performance measures utilizing HEDIS specifications.

The quote "**If you cannot measure it, you cannot improve it**" has never been truer than in today's healthcare environment, where improving clinical quality, enhancing the member experience, decreasing costs, and boosting provider satisfaction requires tracking and validation of PMs to drive outcomes. PMV is critical to the PM reporting process, as it ensures PMs are calculated in a standardized format with consistent application of technical specifications such that each MCO is reporting the PM consistently and that the results are an accurate representation of how the Medicaid Program is performing against Puerto Rico's QMS goals.

As an EQRO, Mercer has been validating PMs for over 14 years and has a standardized, robust process to evaluate, validate, and report information regarding MCO PMs. We have also included an independent HEDIS-certified auditor Jennifer Lenz, who has **performed over 300 HEDIS, pay-for-performance, and wellness program PM audits, functioning as the lead auditor in commercial, Medicare, Medicaid, and CMS data validation**. While HEDIS measures remain a focus for CMS through their inclusion within the CMS Adult and Child Core Measure Sets, our Mercer team has experience validating a wide range of healthcare PMs, including state-developed measures, AHRQ Prevention Quality Indicators and Pediatric Quality Indicators, standardized national measures, including National Quality Forum-endorsed measures, HEDIS, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and CMS' Adult and Child Core Measure Sets.

Beyond evaluating the consistent use of HEDIS technical specifications, our Mercer team has extensive experience with managed care information systems that allow the team to quickly identify potential PM reporting issues stemming from the information system architecture or data exchange, or issues integrating data sources from delegated vendors or external data registries (for example, immunization registries, electronic health records). Each of these steps in the PM reporting process has the potential for impacting the accuracy of PM reporting and is necessary to evaluate as part of the validation process.

Validation of HEDIS measures follows the same rigorous evaluation for any PM, and Mercer utilizes the CMS *Protocol 2: Validation of Measures Reported by the MCO* Version 2.0, September 2012, and Mercer's internal PMV worksheets based on CMS' *Attachment A: Performance Measure Validation Worksheets*, enhanced to improve functionality, data display, and reporting. To execute the CMS EQR protocol for PMV, Mercer conducts three activities:

- Activity 1 is Pre-On-Site Activities
- Activity 2 is On-Site Activities
- Activity 3 is Post-On-Site Activities, all of which are consistent with CMS EQR Protocol.

Activity 1: Pre-On-Site Activities — RFI and Desk Review

The following steps outline the project management approach and information to be gathered before Mercer completes the on-site review/interviews:

1. **Define the scope of the validation:** The Mercer PM team lead will initiate a PM project planning meeting with PRMP to discuss your expectations for HEDIS PMV of the MCOs. This discussion results in detailed information on the HEDIS PMs required, methods for reporting measures (administrative versus hybrid), and expectations for reporting format, as well as solicits input on areas of concern with MCO performance and data availability. Following the initial planning discussion, Mercer will develop a formal methodology

document and submit it for PRMP review before the initiation of the PM activity. The formal methodology document will detail the contract year's methods for conducting the PMV activity, including the number of MCOs required to report PMs for a given year, the PRMP-selected HEDIS PM set, and a proposed work plan that includes key milestones, targeted dates of completion, and the responsible organization. Upon approval of the methodology document, the Mercer team will develop a PM reporting template that includes the following information, as outlined in the CMS protocol:
   - Eligible population
   - Data collection methodology
   - Sampling methodology (if used)
   - Denominator calculations
   - Numerator calculations
   - Calculated and reported rates
2. **Develop a PM worksheet:** Mercer will develop a PMV worksheet to assess the accuracy of the reported results and the extent to which the MCOs followed the HEDIS® measures' specifications. Mercer will employ the MercerConnect® site to support within-team and between-team project efficiencies for validation and PM activities. MercerConnect allows secure documents, such as source code, medical record data, and large data sets, to be shared easily and securely.
3. **Assess the integrity of MCO's information system:** We will conduct this step in the protocol in conjunction with the ISCA. The ISCA results are fundamental to determining whether the required HEDIS PMs are complete and accurate, and whether MCO data (for example, membership, enrollment, provider data, claims, encounter data, medical record data, and ancillary and supplemental data) are integrated appropriately to calculate PM rates. The PMV participates in these portions of the ISCA review.
4. **Select measures for detailed review:** Concurrent with Step 1, the Mercer team will meet with PRMP to discuss the HEDIS PMs selected for validation. For these measures, Mercer will request additional information, including programming source code, through an RFI communication provided to the MCOs. If an MCO utilizes a certified HEDIS vendor to calculate HEDIS PMs (as is required by the current Plan Vital MCO Contracts) Mercer accepts the validated source code. For non-certified measures, the MCOs are required to submit source code for Mercer review. Once all information is received, Mercer will complete PMV worksheets, consistent with the EQR Protocol.
5. **Initiate a review of medical record data collection:** For the PMs using a hybrid methodology, the Mercer team will validate that the following activities:
   - Confirm medical record review staff has the appropriate experience and credentials.
   - Ensure review tools collect the information required for the measure.
   - Verify the training provided was sufficient to ensure accurate data collection.
   - Confirm a statistically sound assessment of the reviewer's performance was conducted.
6. **Validate medical records:** Mercer will conduct medical record validation on a sample of records for some or all hybrid PMs, depending on the similarity and complexity of the hybrid PMs. Mercer proposes the use of a modified NCQA review approach. In this model, Mercer randomly selects 16 numerator compliant files for submission. If the 16 records contain no errors, the measure passes medical record validation. If we detect an error, we review another sample of 16 records. If we detect no additional errors, the measure passes. If we detect two or more errors on the original sample, or if the second set of 16 records fails, Mercer will work with the MCO to correct the errors. If errors cannot be corrected and the

medical record review fails, Mercer will work with PRMP to determine if the MCO can report an administrative-only rate, or if Mercer determines the PM rate biased.

7. **Prepare for the MCO on-site visit:** Before the on-site visit, the Mercer team will inform the MCOs of the PMV activities that take place on-site, discuss the process for reviewing confidential information, and ensure the appropriate staff and resources are available. Mercer will prepare all agendas and share them in advance with the MCOs. Mercer conducts a pre-on-site conference call with each MCO in advance of the on-site visit to address on-site logistics and address any questions the MCOs may have.

Activity 2: On-Site Activities — Review and Analysis

After the pre-on-site activities are underway, Mercer will focus on the on-site review and analysis steps. Mercer will conduct on-site reviews to gather additional information provided in the ISCA.

1. **Review the information system underlying performance measurement:** As noted in the steps above, the ISCA is a fundamental component of PMV protocol. In addition to participating in and reviewing ISCA findings, the Mercer team will complete the following steps as appropriate for each PM:
   - Interview key staff involved in performance measurement (for example, quality, business intelligence, information system).
   - Review primary source data and data input processes.
   - Review systems and processes for calculating PMs.
   - Observe staff members involved in various steps of calculating and reporting PMs.
   - Review data files to ensure data are stored and processed as described.
   - Evaluate the quality assurance processes to ensure appropriate review and sign off on all PM reporting data.
2. **Assess data integration and control for PM calculation:** The Mercer team will evaluate each MCO's ability to integrate data from all data sources used to calculate each PM rate. This evaluation includes an assessment of the data's flow from the source systems to a data warehouse or repository and the control processes surrounding the PM production data.
3. **Review PM production:** Mercer approaches this step in the validation protocol as the culmination of each of the individual steps described above and evaluates them as a whole. Understanding that a breakdown in any one aspect of the process, from collecting data to integrating data to programming, calculating, and reporting can result in inaccurate calculation and reporting of PMs, a full review of the process is critical.
4. **Conduct a detailed review of selected measures:** For those HEDIS measures that PRMP selects, Mercer will do an in-depth analysis to assess the accuracy of the identification of the population eligible to be included in the measure denominator, the measure numerator, and the resulting calculation. The in-depth analysis includes an assessment of the source code to ensure all specifications, such as age, gender, continuous enrollment criteria, exclusionary criteria, medical event codes, are programmed correctly. In addition to the review of specifications for generating the denominator and numerator, the Mercer team will ensure measures are calculated as required. That is, the team will confirm that measures reported in member months or rates per 1,000 are correct. Furthermore, Mercer will conduct primary source verification on a sample of cases across several measures and trace the sample members back through the source systems to ensure the programming code logic is working correctly.

5. **Assess the sampling process:** For any measures for which the MCOs have conducted sampling, the Mercer team will review the sampling process to validate the sample is representative of the full population for which the measure is being calculated and reported. Mercer has a team of statisticians available to consult on appropriate sampling methodologies and to assess the validity of the sample for a specific measure.
6. **Assess preliminary findings and request outstanding items:** After the on-site portion of the review, Mercer will provide a verbal preliminary assessment of the performance measurement process' validity. Mercer will request any outstanding documentation and provide a timeline for submission so the team can review those items before developing the preliminary validation assessment.

Activity 3: Post-On-Site Activities — Reporting

1. **Determine preliminary validation findings for each measure:** The performance measurement team lead will produce a written preliminary validation assessment. The MCOs will have the opportunity to review the assessment to identify errors or omission in the assessment and, as needed, provide additional documentation to support a recommended correction.
2. **Assess the accuracy of vendor PM reports to PRMP and/or ASES as appropriate:** In this step of the validation process, we will assess if the MCOs submitted reports to PRMP or ASES on time, in the required format, and with the appropriate level of review, and including attestations of such.
3. **Submission of validation report to PRMP and/or ASES as appropriate:** Based on the final submitted PM rates, Mercer will determine whether the rates are valid and reliable for reporting using industry-standard audit bias methodology. Per CMS guidance, information on the PMV will be presented using the Protocol 2 Worksheet 2.14 "Framework for Summarizing Information about Performance Measures." This worksheet includes the following:
   - Overview of Performance Measure
   - Performance Measure Results
   - PMV Status

   Mercer will produce a summary of the PMV results for inclusion in the EQR technical report, with sufficient detail to meet CMS requirements. The MCOs are required to develop a CAP to address all PMV findings. The Mercer team will review the CAP and, as needed, meet with the MCOs to ensure the CAP results in improved compliance results in subsequent review years. Based on our experience, we consider this approach a best practice.
4. **Comparative analysis:** Comparative analysis of the HEDIS results can be very informative to PRMP, ASES, and stakeholders, not just to track and trend results, but to answer broader questions such as, "Is PRMP getting the most value from its MCOs for the premium dollars it is paying?" Mercer will work with PRMP to present the Medicaid (Title XIX population) and CHIP (Title XXI population) HEDIS results in a reader-friendly way. As appropriate and based on the stability of HEDIS measure specifications, we will conduct year-over-year comparative analysis of individual MCO performance, as well as among MCO performance. Within the comparative analysis, we will aggregate and summarize the PM data submitted by the MCOs. Mercer's annual license to NCQA's Quality Compass Medicaid information allows us to include national and regional benchmark information in the comparison report. The comparison of results across entities and with national

information assists PRMP and ASES in assessing its value position with the MCOs. Mercer has prepared this type of comparative report for several clients in a variety of formats. Included in Appendix C is the Delaware Technical Report as an example.

As a value-added benefit, Mercer has corporate resources that, as an expanded scope of work, can develop brief (one or two pages) infographics to "tell the story" of the Medicaid program and the progress toward meeting QMS goals. Our clients have found this tool useful not only as an internal means of sharing how the Medicaid Program is performing with senior leadership, but also for sharing the program's progress with the general public or government legislators.

Provide a work product sample which was collaborative effort between the respondent's biostatistician, epidemiologist, medicine doctors and other EQRO staff. Information/identifiers should be stricken from the document prior to submission.

Mercer frequently supports our clients with focused studies and program evaluations that include our statistician, physicians, and other EQRO staff. New Mexico, Colorado, Missouri, and Delaware requested Mercer support for development of a program evaluation strategy that includes the development of a Logic Model or Driver Diagram. We have assisted with development of these models that lead to evaluation plans. Our proposed evaluation plans and on-going execution of the evaluation plans require a collaborative effort among our clinicians, statisticians, and the client.

More specifically, in our role as DE's EQRO partner, Mercer has completed EQR federal-match compliant quality and oversight focus studies. EQR optional focus studies are a valuable tool for PRMP to oversee specific aspects of the program that are high visibility and high impact, as they allow you to ensure the MCOs participating in PRMP's program are properly providing quality and cost-effective care.

Mercer collaboratively works with you to ensure the topic of the focus study is meaningful and actionable for the population served. Upon approval of the study, Mercer will create a project charter outlining the project team and responsibilities and schedule a kick-off meeting. This meeting intends to review the project plan, calendar timelines, and key deliverables. We have learned that focus studies proceed more efficiently when our client designates a steering committee or executive sponsor to champion the study, and encourages PRPMP to consider this approach. Mercer will facilitate all subsequent meetings with the MCOs or other program vendors as appropriate and agreed to by PRMP.

The core focus study team may include clinicians, statisticians, healthcare analysts, and informatics specialists. Additional SMEs can be engaged, as needed, based on the topic being studied. For example, we can access our pharmacy and SUD clinicians for studies related to opioid prescribing and management, we can bring in our dental expert to address topics related to dental benefit management, or our clinical quality specialists in children's health to address EPSDT and foster children systems of care.

The work product provided in Appendix E is an example of a focus study conducted by Mercer to identify differences in treatment outcomes among Medicaid MCOs for members prescribed

buprenorphine. This study was led by our EQR team and a pharmacist from Mercer's Pharmacy team in consultation with the Medicaid Pharmacy Director, acting as the Executive Sponsor, and included subject matter expertise from our psychiatrist with specialty expertise in SUDs, our statistician, and BH team members.

The study was designed to compare Medicaid rates of initiation and engagement of alcohol and drug treatment visits to the national benchmarks and evaluate outcomes, including emergency department visits, overdose visits, and opioid-related deaths among the State's MCO vendors.

Key recommendations included the continuation of emphasis on appropriate opioid prescribing protocols and alternative pain management approaches and continued use of the prescription monitoring database. Mercer's pharmacist summarized and presented the study results to the Medicaid Director and Deputy Director. Mercer was asked to perform a follow-up study based on several of the recommendations from the base study.

Describe how the respondent will train and educate staff regarding contractor responsibilities described in the scope of the contract.

Mercer's contract and project management approach begins with all team members reviewing the EQR contract, EQR scope of work, EQR Protocols, and the Plan Vital MCO model contracts. Our work plan includes time and resources to support both staff training and their work tasks. Mercer develops staff training programs using adult learning principles and requires training for any staff who has regular, advisor, or as needed responsibilities within the EQR contract. This level of training is critical for EQR contracts due to the regulatory nature of the responsibilities and the need to understand the state-specific priorities. We also conduct in-depth training for any staff who administer or use the tools for completing and reporting findings from the external review.

We believe that collaborating with PRMP is the best method to assure Mercer trains our EQR team on contract responsibilities. Upon approval by PRMP, the Mercer Puerto Rico client leader and EQRO project leads will conduct the kick-off training with the EQR team. Examples of content the kick-off training may focus on include:

- Medicaid Population in Puerto Rico
- Overview of Medicaid Agency (including differences in the PRMP)
- Review of MCOs (Medicaid and Medicare Advantage plans) including model contracts
- PRMP QMS
- EQRO Contract Responsibilities, deliverables, and schedules
- CMS EQR Protocols
- EQRO Staff Roles

Additional EQR staff training is offered a minimum of annually to assure effective implementation for EQR activities. Of particular focus is training on survey tools, which includes time set aside for inter-rater reliability (IRR) training and testing for the file review tool, PIP documentation, and any other auditing processes. To increase the validity of auditing, and thereby increase the defensibility of its use, Mercer not only provides training on how to administer the tool but also conducts IRR exercises that ensure all trainees follow the same process and reach similar conclusions. Mercer has found there is tremendous value in having state agency staff attend the kick-off and ongoing trainings related to the contract, and your input will allow Mercer to improve and customize our EQR training activities to meet the specific needs of PRMP.

Describe how the respondent will monitor and ensure inter-rater reliability among the audit staff. Describe internal controls to help assure accuracy and completeness of required reporting.

Performing IRR training and testing increases both the validity of the review tools used and the final EQR results, strengthening the validity of the review, and is required for all staff conducting EQR review tasks. Obtaining consistency within our team is a focus area for Mercer in any review process, especially EQR reviews, and our team has experience designing and conducting IRR training and testing for all team members performing review activities. We provide training to the team on how to use the EQR tools and conduct IRR exercises prior to and throughout the review to ensure all team members follow the same process and reach similar conclusions. This additional step increases confidence in the results gathered from the use of the tool and provides support for any conclusions drawn from the results.

As part of the IRR testing, the EQR project leads establish a baseline for the appropriate scoring using a pre-determined scenario. After the team receives training on the proper use of the EQR tools, team members examine the pre-determined scenario using the review tool. The team members' results are compared against the gold standard. Only team members who score within 95% of the gold standard will be cleared to administer the review tool. IRR review is ongoing throughout the project (e.g., spot checks by the EQR lead) and the identification of any inconsistencies will result in additional training to ensure ongoing rigor in the review process. For the interview portions within the tools, Mercer's EQR project leads evaluate the trainees' ability to administer the tools consistent with interview standards through role-playing exercises.

- Tool and Audit Administration Standards
- Interview Standards
- Group Interview Tool and Practice Exercise
- Group Interview Role Play Assessments
- File Review Tool and Practice Exercise
- IRR Testing for File Review Tool

While not part of our formal IRR training, Mercer institutes a rigorous review of all findings by secondary reviewers through our peer review process. All EQR reviews, findings, and report writing are reviewed by a minimum of three Mercer staff — the lead reviewer/writer, the peer reviewer, and the EQR lead — prior to finalization.

Describe any current or previous EQRO experience with population health or disease management evaluation methods. Describe how the respondent will monitor and provide feedback to PRMP regarding the efficacy of MCO population health and or disease management protocols and interventions.

Moving to whole-person models that emphasize identifying and addressing SDOH and health disparities within the membership and applying a comprehensive population health model to managing their care is critical to achieve meaningful improvements in health and well-being and reducing health inequities.

As a component of the Compliance Review, Mercer evaluates the MCOs care management program against model contract requirements (currently section 7.8.2 of the Model Contract) and how effective the program is at engaging members into care management and if the program is successful at linking members to necessary services and improving health outcomes. This is done through and evaluation of MCO policies and procedures, on-site interviews with MCO care managers and supervisors, and medical record file reviews and will include an evaluation of care management for required populations such as those members with High-Cost, High-Needs.

Currently, the Model Contract requires MCOs to have a care management program, and no requirements around population health management. The move to a population health model is one that many Medicaid programs are taking and Mercer is excited to assist PRMP in building a Population Health Model that is reflective of the unique needs of the Puerto Rico Medicaid population. Mercer is a sought-after consultant and thought leader in the area of population health. Mercer's Population Health Framework covers more than MCO population care management to include the highly related concepts of VBP models that reward value, reducing health disparities and addressing SDOH.
Since Elizabeth Bradley's groundbreaking research[2] into the impacts social determinants have on healthcare costs and outcomes, identifying SDOH has become a focal point in managed care programs. Mercer's Population Health Framework considers an array of factors, including addressing SDOH, to assist our clients in developing a population health strategy that addresses the whole person, including their cultural and social needs. The implementation of SDOH screening as a required function, and incentivizing and collecting SDOH z-coding from providers, are just some examples of efforts states and managed care plans have implemented to address identified insecurities in SDOH areas, such as housing, food, financial assistance, ability to find work, and childcare.

Too often, however, our Mercer team has seen limited success beyond simply identifying a SDOH need and giving the member a referral or phone number for a community resource organization that they may or may not access. In our experience, there is significant opportunity in five key SDOH areas:

- Execute contract requirements for robust community-based organization (CBO) and MCO partnerships with clear referral processes.
- Develop a feedback loop (sometimes called closed-loop referrals) in which it is known when a member accesses a community support resource that can be documented in the member's clinical record for tracking and reporting.

[2] Bradley, Elizabeth H., and Lauren A. Taylor. The American Health Care Paradox: Why Spending More Is Getting Us Less. New York, NY: PublicAffairs, 2013.

- Follow-up with members to ensure the insecurity was fully resolved.
- Develop value-based financing models that support the increased services CBOs provide as referrals increase and enable CBOs to earn more for positive member outcomes.
- Increase z-code reporting by providers who conduct SDOH screenings, which provides a key data source to PRMP and the MCOs to evaluate the SDOH needs within the population and use that information to inform improved services, clinical programs, supports, and CBO partnerships.
- Develop reporting tools to analyze disparities contributing to variances in clinical outcomes.

Mercer looks forward to working with PRMP to advance your population health model in ways that are aligned with Puerto Rico's QMS and that meaningfully address SDOH.

MERCER IN ACTION

In 2018, the Delaware DMMA engaged Mercer to develop their approach to SDOH within Medicaid managed care. Mercer partnered with the Center for Health Care Strategies and assisted in the following areas:

- **Providing SDOH training to State Medicaid staff.**
- **Facilitating DMMA's Medicaid SDOH workgroup.**
- **Assisting DMMA to identify priorities, potential partners, and desired timeline for implementation.**
- **Engaging stakeholders (MCOs, providers, and sister state agencies) to better understand barriers and opportunities.**
- **Identifying potential SDOH screening tools.**
- **Developing draft managed care contract requirements related to SDOH.**
- **Developing an MCO incentive payment program.**

Describe the mechanism the respondent will use to remain current on state and federal requirements related to MCO's.

Mercer GHSC is a national leader in Medicaid and federal health policy. Our clients rely on Mercer to stay abreast of current federal requirements and policies affecting how they operate their healthcare programs. If you choose Mercer as a partner, PRMP will have the support of our Policy and Operations Sector, which comprises health policy experts who are former CMS and state Medicaid administrators. This team conducts regular monitoring and analysis of federal policy changes, has deep relationships with CMS officials, and, since many are former CMS officials, gives Mercer unique insights that will be an asset to your EQR team and PRMP.

The EQR team comprises industry professionals with decades of EQR, Medicare Quality Organization, and health plan experience who understand that continuous learning and evaluating guidance from CMS is a critical component of our jobs. Our EQR team is committed to keeping a pulse on new or revised guidance from CMS and other authorities and sharing our knowledge with PRMP through notices and TA whenever appropriate or relevant.

Describe ongoing internal controls to safeguard access to data as well and the respondent contingency plan for data systems failure in any critical EQRO areas.

Business Continuity Policy

For security reasons, business continuity and disaster recovery plan documents for Marsh McLennan and its subsidiary companies are not permitted to be shared with external parties. A copy of Marsh McLennan's Statement of Recoverability, which describes our business resiliency and disaster recovery preparedness programs, is provided in Appendix B.

The following information details Mercer's proposed approach to ensure proper security of Medicaid data and how the respondent will restrict access in compliance with HIPAA standards.

Mercer's policies and procedures are supported by senior management and are based on common cybersecurity frameworks and standards, including, but not limited to, ISO\IEC:27001 and the NIST SP800-53 Risk Management Framework. GHSC's ultimate parent company, Marsh McLennan Companies' information security policies and procedures outline the roles and responsibilities for our colleagues and allow Mercer to take disciplinary action for violation of the policies, up to and including termination of employment or contract for services. Mercer also recognizes the importance of protecting and managing personal information. As such, there are policies, programs, and procedures in place to protect Mercer and client personal information from loss or misuse, and comply with applicable data privacy laws.

To ensure HIPAA privacy and security rules are enforced, Mercer controls, stores, and transmits all PHI in compliance with HIPAA requirements, industry standards, and Mercer confidentiality policies.

Mercer uses and supports a variety of encryption and transmission methods to exchange sensitive data with clients, including Transport Layer Security (TLS v1.2 and v1.3) encryption, secure file transfer solutions, and other encryption solutions such as WinZip and PGP (AES 256). Portable device encryption is deployed to Mercer laptop and desktop computers and computers are required to have whole-disk encryption (AES 256) installed and enabled. Back-up tape encryption (AES 256) is in place globally. In addition to encryption (where used), Mercer uses a layered approach to security ("defense in depth"), including, but not limited to, physical security; logical access; and password management controls, including, but not limited to, physical security, logical access and password management controls, multi-factor authentication, server and network device event log management and monitoring, and network security (for example, firewalls, IDS/IPS, and DLP).

Access to PHI is restricted to specific team members only and requires special permissions to access the information. In addition to restricting access to PHI, all Mercer employees have received mandatory HIPAA training. Mercer also uses HIPAA compliant encryption software for data transfer.

Traffic and network monitoring software and tools are continuously used to flag unencrypted messages that may contain PHI and prevent it from being transmitted externally.

Access to data stored on network drives is controlled by setting permissions at a directory level. Only authorized users can view the files that are stored in a directory and access their content. The HIPAA compliance officer controls permissions to access these directories. All access requests must be submitted in writing to the HIPAA compliance officer. Mercer's project manager(s) reviews every access request for each project to verify the staff member making the request needs access to the requested directories. Network permissions are reviewed regularly and compared to current project assignments. Permissions are removed for staff members no longer working on a project.

GHSC's ultimate parent company, Marsh McLennan, has committed to protect, preserve, and recover enterprise resources, including, but not limited to, personnel, facilities, software, IT systems, and information assets such as master files if a disruptive event occurs. Marsh McLennan's technology organization develops and maintains Disaster Recovery plans for all Marsh McLennan operating companies (including Mercer Health & Benefits LLC) with procedures and capabilities for recovery of network and telecommunications systems, recovery of critical business applications, and restoration of data. An overview of Marsh McLennan's Disaster Recovery Plan is below.

Marsh McLennan's Disaster Recovery plans include:

- Strategies to restore IT applications and services within a specific timeframe.
- Key stakeholders and contacts for every system and application.
- Detailed step-by-step recovery runbook.
- Strategies to foster the restoration of data within a specific time period following a disaster.
- Ongoing cross-site replication of critical or high-volume data.
- Technology team notification procedures and details.
- Disaster impact assessment, timetables, and action plans — recovery point objectives.
- Contingency plans to replace computing equipment.
- Contingency plans to use other corporate data centers and resources in the event of a disruption.

Upon notification of contract award and determination of applications and services within the scope of the contract, GHSC will work with the PRMP to develop a mutually acceptable contract-specific Disaster Recovery Plan to ensure applicable software applications, master files, and hardware backup are restored in the event production systems are disabled or destroyed. In the unlikely event of a service interruption, the goal will be to limit such a disruption to no more than twenty-four (24) clock hours.

Statement of Recoverability

Protection of information and continuation of services, even in the event of a disaster, is a cornerstone of Marsh McLennan's commitment to its clients. To support that commitment, Marsh McLennan maintains a robust business resiliency program that includes:

- Conducting Business Impact Analyses.
- Establishing and maintaining business resiliency, disaster recovery, crisis management, and incident response plans.
- Performing periodic assessments of key third-party dependencies.

- Periodic testing of disaster recovery capabilities and exercising of response plans to validate our ability to serve and support our clients in the event of a disaster or other business disruption.

Describe in detail how the respondent would plan and host meetings with MCOs and interrelated oversight agencies.

Mercer understands PRMP is the agency responsible for overall management of the Medicaid program and works with ASES to administer the managed care aspects of the program. Mercer will work with PRMP in identifying a meeting cadence with ASES and other interrelated agencies as appropriate. A key component of the relationship between Mercer and PRMP will be ongoing meetings and communications with PRMP, the plan MCOs, ASES, and other agencies and entities identified by PRMP. Mercer designs meetings that are focused, organized, and efficient, with a clearly defined purpose and agenda. In advance of any scheduled meetings, Mercer will provide an agenda and any necessary supporting documents for PRMP review and approval. We will document meeting discussions and generate a meeting summary with clearly identified action items, timeframes, and responsible parties. We will share meeting summaries and action items with meeting attendees. Documenting discussions and decisions during meetings will keep projects moving forward, inform next steps in the process, and identify areas that require additional discussion.

Mercer will schedule and host meetings with PRMP, MCOs, and interrelated oversight agencies **using Zoom software. If PRMP prefers another platform, such as WebEx or Teams, we will accommodate that requirement.**

To facilitate information sharing, Mercer will implement a shared site using Mercer's PHI-compliant Connect Share Point site, "MercerConnect." The MercerConnect site allows any PRMP team members granted access (access that will be maintained by your EQR project manager) to “drag and drop” documents, including meeting agendas, meeting minutes, and other documentation between their local computer and the MercerConnect site. Therefore, Mercer and PRMP are able to place items on the site for the other to view. In addition, access to each folder or file can be limited to certain users if the site contains sensitive information. MercerConnect users can even receive instant or daily automatic email notices when new items or documents are added to the site. This secure MercerConnect site facilitates anytime access to a variety of project tools, including documents, correspondence, deliverables, and presentations.

In our experience working with state Medicaid programs, MCOs appreciate clear communication to understand their responsibilities and PRMP’s expectations, as well as opportunities to ask clarifying questions regarding the process and submission materials. Meetings can be via video conference using platforms such as Zoom or Microsoft Teams, or may be conducted in person if desired by PRMP. MCOs frequently have staff turnover, meaning MCOs may or may not have staff who have experienced an EQR and therefore need additional communication to ensure the review is effective and that submissions meet the EQR and PRMP’s expectation. At a minimum, Mercer will provide MCOs:

- In advance of the release of the EQR RFI: This session (held before the release of any RFI sent by the Mercer EQR team) is conducted to ensure the RFI is reviewed in detail with the

MCOs and that they have a good understanding of the documents requested, how and where to submit requested materials, and timelines and due dates. It also provides the MCOs an opportunity to ask questions about the process.

- In advance of the on-site review: This session is held prior to the Mercer and PRMP team's on-site review with the MCOs and is designed to share the on-site agenda, ensure the MCO knows the staff who must be present during the on-site reviews, any presentations or demonstrations they may need to prepare (for example, the EQR team may request a demonstration of the MCO's care management platform or wish to sit in on member services calls), and overall expectations of the on-site portion of the review.
- After the EQR, Mercer will provide a review of the recommendations or corrective actions identified during the review.

Provide narrative describing that respondent is QIO or QIO like entity as required by federal law for services contained in this procurement, along with any proof of designation.

As noted in the Q&A responses, QIO and/or QIO-like requirement has been removed and is not required for this engagement.

Appendix A

Authorization to Sign

Certificate authorizing Jessica Osborne, Principal, as an authorized signor for Mercer are located on the following pages.

Mercer

CERTIFICATE OF THE ASSISTANT SECRETARY

OF

MERCER HEALTH & BENEFITS LLC

I, Margaret M. O'Brien, Assistant Secretary of Mercer Health & Benefits LLC, a Delaware limited liability company (the "LLC") certify that on February 11, 2010, the Board adopted procedures authorizing any Principal, Partner or Senior Partner of the LLC including Jessica Osborne, Principal to execute contracts, agreements, applications and other instruments on behalf of the LLC. This resolution has neither been amended nor rescinded and remains in full force and effect as of the date hereof.

IN WITNESS WHEREOF, I have set my hand and the seal of the LLC on this 13th day of January 2022.

Margaret M. O'Brien
Assistant Secretary

State of New York)

County of New York)

Subscribe and sworn to before me on this 13th day of January 2022.

Notary Public

Sandra Davenport
Notary Public - State of New York
No. 01DA6135698
Qualified in Nassau County
Certified in New York County
Commission Expires February 20, 2022

MERCER HEALTH & BENEFITS LLC

(Delaware)

(the "LLC")

CONSENT TO ACTION WITHOUT A MEETING OF THE BOARD OF DIRECTORS

The undersigned, being all the members of the Board of Directors of this LLC, hereby consent to the following action being taken without a meeting:

RESOLVED: any employee of this LLC who has achieved a grade level "E" is automatically elected to serve in the office of Associate of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "F" is automatically elected to serve in the office of Senior Associate of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "G" or a grade level "H" is automatically elected to serve in the office of Principal of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "I" or a grade level "J" is automatically elected to serve in the office of Partner of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: the President of this LLC may appoint employees to serve in the office of Senior Partner of this LLC and each such Senior Partner shall serve in such office until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: that any elected Principal, Partner or Senior Partner of this LLC is authorized and empowered, in accordance with the guidelines set forth in the then in-effect Mercer Approval Procedures, to execute contracts, agreements, applications and other documents on behalf of the LLC.

Effective: February 11, 2010

Thomas L. Elliott

Roy A. Gonella

Diane O'Neill

Appendix B

Statement of Recoverability

MARSH & McLENNAN COMPANIES

Statement of Recoverability

MARCH 2021

OUR COMMITMENT TO PREPAREDNESS

The leadership of Marsh & McLennan Companies (MMC) has committed to protect, preserve and recover enterprise resources (for example, personnel, facilities, equipment, IT systems and information assets) if a disruptive event occurs.

As an integral part of our operations, we plan for the continuity of business and service to our clients. We are committed to ensuring that our Business Resiliency, Disaster Recovery, Crisis Management and Incident Response plans are reviewed, updated and tested regularly.

STATEMENT OF RECOVERABILITY

Protection of information and continuation of services, even in the event of a disaster, is a cornerstone of MMC's commitment to its clients. To support that commitment, we maintain a robust business resiliency program which includes:

- Conducting Business Impact Analyses (BIAs).
- Establishing and maintaining business resiliency, disaster recovery, crisis management, and incident response plans.
- Performing periodic assessments of key third-party dependencies.
- Periodic testing of recovery capabilities and exercising of response plans to validate our ability to serve and support our clients in the event of a business disruption.

BUSINESS RESILIENCY MANAGEMENT (BRM) GROUP

The Business Resiliency Management (BRM) group provides business continuity guidance and overall program management, including compliance monitoring, to all of our businesses and corporate functions:

- Marsh
- Guy Carpenter
- Mercer
- Oliver Wyman
- MMC Corporate

The BRM group coordinates communications and other shared resources, including emergency communication systems, business resiliency planning systems and external vendor capabilities such as work area recovery.

BUSINESS RESILIENCY PLANNING

Our critical business and corporate functions maintain Business Resiliency plans with specific provisions for colleague mobilization, alternate work spaces, and communication with clients and critical third parties. These plans are created based on a Business Impact Analysis that identifies business recovery requirements and priorities.

The Business Resiliency plans address loss of:

- Office facilities and personnel.
- Critical applications.
- Mission-critical functions and processes.
- Key third-party providers.

Critical MMC operations and functions are required to maintain copies of their current Business Resiliency plans on the Business Resiliency Management plan digital repository and, as they deem necessary, in hard copy.

Business Resiliency plans include:

- Key stakeholders and contacts for every critical operation and function.
- Detailed step-by-step business operation recovery playbook.
- Incident impact assessment, timetables and action plans, including recovery time objectives (RTOs).
- Plans for implementing long- and short-term alternate operations.
- Contingency plans to use other corporate or operating company offices, service centers and resources in the event of facility loss.
- Contracts with external parties for work-area equipment and facilities.

DISASTER RECOVERY PLANNING

Our technology organization develops and maintains Disaster Recovery plans with procedures and capabilities for recovery of network and telecommunications systems, recovery of critical business applications, and restoration of data. These plans are created based on a BIA and an application risk analysis that, combined, identify requirements for technology recovery.

The Disaster Recovery plans address loss of:

- Network services
- Databases
- Operating systems
- Critical applications

Disaster Recovery plans are kept and maintained by the operating company technology organizations; copies are also maintained by the technology infrastructure organization, centrally.

Disaster Recovery plans include:

- Strategies to restore IT applications and services within a specific time frame.
- Key stakeholders and contacts for every system and application.
- Detailed step-by-step technology recovery runbook.
- Strategies to foster the restoration of data within a specific time period following a disaster.
- Ongoing cross-site replication of critical or high-volume data.
- Technology team notification procedures and details.
- Disaster impact assessment, timetables, and action plans – recovery point objectives (RPOs).
- Contingency plans to replace computing equipment.

- Contingency plans to use other corporate data centers and resources in the event of disruption.

ALTERNATE WORK SITES

MMC uses a multi-layered approach to providing alternate work sites in the event that an office suffers a service interruption. This approach is aligned closely with each of our businesses and functions, and it recognizes important support requirements and interdependencies of all phases of our operations. In this matrix approach, our colleagues may work from one of the places below when a business resiliency plan has been activated:

- Home, using high-speed Internet connections and Virtual Private Networking (VPN) to access company network and resources.
- An alternate work space, where prior arrangements for recovery support have been made.
- Commercial recovery service centers and mobile work sites.
- Other corporate or operating company offices (with or without the transfer of colleagues from the affected locations).

Should there be a complete facility outage, critical operations of an affected office will be deployed to the alternate location(s) and processes resumed. Additional equipment and facilities will be made available as required for the scale the processes require.

TECHNOLOGY RESILIENCE

Local Office

Networks in all MMC offices use a fault-tolerant approach to system designs. In other words, we have implemented technologies that limit our vulnerabilities in case of a systems failure, office location failure or natural disaster. Each office's computing environment is established using global standards that facilitate remote support.

Data centers and server rooms are protected against unauthorized access, environmental hazards using dedicated fire response protection, moisture detection and cooling systems, as well as backup and uninterruptible power supply (UPS) systems.

MMC uses a range of commercial and custom bespoke software applications. The Company's businesses maintain dedicated technology or solutions delivery teams that are responsible for application development and maintenance.

Data Centers

MMC operates data center facilities throughout the world with primary and secondary data centers housed in each of three key regions - the US, UK and Australia.

Data centers are configured with redundant power feeds, telecommunications circuits, back-up generator power and UPS systems. Server rooms are configured with UPS systems and depending on the facility's size, there may be on-site back-up power, such as a generator. Such systems are tested on a periodic basis (e.g., quarterly, semi-annually) depending on system and location.

Critical applications are designed for high availability, using clustering or load-balancing technology. Disaster recovery strategies are implemented based on business-defined requirements, including near-time replication to meet business recovery time objectives.

MMC also has dedicated business resiliency and disaster recovery teams that coordinate the Company's capability to recover systems and provide work areas using internal or external resources. Solutions are designed to meet requirements defined by impact analyses of system or facility outages. Where appropriate, human or computer workload is distributed among multiple locations to reduce or eliminate downtime due to local outages.

Disaster recovery tests are coordinated by the Company's technology infrastructure organization working with internal business IT teams and application owners. Test objectives are defined and agreed to by the business lead, business IT support lead, and technology infrastructure leads.

Data Backup

We back up critical data nightly (differential backup) and weekly (full backup). Backups are stored both at offsite storage facilities and in secured onsite data-storage facilities. We also perform cross-site replication of critical or high-volume data. The standardization of backup systems and storage procedures across our offices enables recovery efforts at alternate sites.

Cyber Security

MMC has established internal controls for the protection of its information assets, and to comply with business and regulatory requirements. These controls, which include related planning, development and implementation of appropriate policies and procedures, are reviewed regularly and updated where applicable to ensure the integrity, availability and confidentiality of corporate and client information.

We maintain an incident response plan with designated incident response leaders who assemble the necessary personnel to promptly respond to computer security incidents. The plan focuses on preparation, detection, analysis, containment, eradication, recovery and post-incident improvements. This response capability addresses events such as cyber-attacks, data loss, malware/virus infections, denial of service (DoS) attacks, critical system outages, violations of security policy, imminent threats and suspected breaches.

CRISIS MANAGEMENT

Structure

MMC uses a tiered crisis management and response structure that emphasizes activation of teams tailored to the situation and its potential impacts. The overarching goal is to minimize adverse impact on the Company, its colleagues, assets, business operations, clients, and reputation.

- Responses are managed as close to the incident as possible.
- Coordination is facilitated within and across MMC operating companies via local, country and corporate crisis response teams.
- Key response teams are exercised on a regular basis via scenarios for role and response capability.
- Leadership is kept appraised of incidents, and possible impacts, through regular updates.

Response

The crisis management and response structure recognizes and aligns all aspects of response from immediate, tactical emergency response to executive strategic decision-making on critical business, financial and policy issues. This streamlined approach:

- Provides an overall response structure, with clarity in "division of labor" among teams and levels.
- Supports a common, comprehensive and predictable management response process, while providing flexibility to adapt to each situation.
- Crosses operational/business lines and promotes consistent, cross-functional support.
- Provides immediate, proximate assistance and resources where/when able.

PANDEMIC PREPAREDNESS

MMC's Business Resiliency Management Group, in concert with our Health and Life Safety Committee, identifies and assesses issues relating to communicable diseases and develops and helps implement protocols to mitigate the effect they may have on our operations, our colleagues, and our ability to serve clients.

The Business Resiliency Management Group and Health and Life Safety Committee also monitor and develop responses to communicable disease issues, including actual and potential threats, supported by third-party advisors and by risk and pandemic preparedness experts at our operating companies, including Marsh and Mercer.

SUCCESSFUL PLAN EXECUTION

MMC has successfully supported critical business activities during disruptions of normal business processes resulting from both natural and man-made disasters. On each occasion that plans have been invoked, they have been executed successfully. Some examples include:

- Potential Mass Transit Outages: United States.
- Acts of Terrorism: United States, Belgium, UK, India, Norway, France, Turkey, Sweden and Spain.
- Hurricanes: Bermuda, Cayman Islands, United States, the Dominican Republic and Ireland.
- Typhoons: Japan, China, Taiwan, Hong Kong, India, Fiji and the Philippines.
- Pacific Tsunamis.
- Flooding: Thailand, Indonesia, India, the Philippines, UK and Australia.
- Wildfires: United States, UK, Australia and India.
- Communicable Disease/Pandemics: Global COVID-19 Outbreak, Sudden Acute Respiratory Syndrome (SARS), Influenza (Swine & Avian Flu), MERS-CoV and Ebola.
- World Trade Organization (WTO) and G8/G20 Global Summit Meetings: United States and Canada.
- Earthquakes and Volcanic Eruptions: Chile, New Zealand, the Philippines, Japan, Iceland and Mexico.
- Superstorm Sandy.
- Political unrest and demonstrations: Egypt, Indonesia, Brazil, Thailand, Israel, Ukraine, Hong Kong (Occupy Central), Turkey, Spain, South Korea, India and Indonesia.

FREQUENTLY ASKED QUESTIONS

1. Does your organization have a dedicated team focused on Business Continuity and/or Disaster Recovery?

   MMC has dedicated business resiliency and disaster recovery teams that coordinate the Company's capability to recover systems and provide work areas using internal or external resources.

2. What criteria are used for the creation of recovery strategies in Business Continuity and/or Disaster Recovery?

   Solutions are designed to meet requirements defined by impact analyses of system or facility outages. Where appropriate, human or computer workload is distributed among multiple locations to reduce or eliminate downtime due to local outages.

3. I would like to review a copy of your Business Continuity ("BC") or Disaster Recovery ("DR") Plan. Do you allow this?

   In order to protect our intellectual property, client confidentiality and colleague personal identity information, we do not release our documented BC or DR plans.

4. How often do you test / exercise your Business Continuity and/or Disaster Recovery plans?

   Our plans are tested / exercised on a regular and representative basis. Using a risk-based approach, we do not test / exercise all plans on the same schedule.

5. What methods of testing / exercising do you undertake?

   We employ a range of test / exercise methods, as appropriate. Representative examples include:
   - *Remote access (e.g. work from home, work from a different office)*
   - *Commercial work area recovery exercises*
   - *System fail-over testing, including external vendors where appropriate*
   - *Evacuation drills, notification system tests and periodic generator tests*

6. Can I participate in, or observe, the performance of a Business Continuity or Disaster Recovery exercise/test?

   In order to protect our intellectual property and client confidentiality, we do not permit third-party observation of, or participation in, our exercise or test activity.

7. What is the expected recovery time objective for critical business functions?

   Recovery time objectives vary based on requirements defined through the Business Impact and Application Risk Analyses.

Appendix C

Delaware Technical Report

Mercer

2021 External Quality Review

[redacted]

[redacted]

[redacted]

December 29, 2021

BRIEF VERSION

[redacted]

Contents

1

Executive Summary

Mercer Government Human Services Consulting (Mercer) conducted an external quality review (EQR) of [redacted] at the request of the [redacted] and State), [redacted], in accordance with 42 CFR Part 438, Subpart E. During this annual EQR cycle, a managed care organization (MCO) comprehensive review was conducted with [redacted]. The content of the EQR included the following areas:

- Comprehensive compliance review of [redacted] with Federal Regulations for Medicaid Managed Care (FRMMC) and State standards.
- Compliance with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).
- Compliance with contract standards for:
  - Diamond State Health Plan (DSHP) Plus case management (CM).
  - DSHP All Member Level Care Coordination (CC), Level 1 Resource Coordination, and Level 2 Clinical Care Coordination (CCC).
- Performance improvement project (PIP) assessment.
- Performance measure (PM) assessment.

The purpose of this independent review was to:

- Assess compliance with all federal regulations pertaining to Medicaid and Children's Health Insurance Program (CHIP) managed care programs in 42 CFR part 438 and 42 CFR part 457, respectively and state-defined standards.
- Assess the ability of [redacted] and its programs to achieve quality outcomes and timely access to health care services for Medicaid, CHIP, and DSHP Plus members enrolled in [redacted] and covered under its contract with [redacted].
- Review the consistency of [redacted] internal policies, procedures, and processes.

To complete this review, Mercer applied FRMMC, CHIPRA, and State regulations, contractual requirements, [redacted] internal policies and procedures (P&Ps) and state-defined standards communicated to the MCO through its managed care contract and the Medicaid/CHIP/DSHP Plus Quality Management Strategy. The table below provides a sense of [redacted] progress toward full compliance with expectations by review area.

[redacted] Comprehensive Review		
EQRO Review Sections	**Number of Items Reviewed**	**Items Needing CAP from 2021 EQR**
Administration & Organization	59	3
CC	54	6
Dental	28	0
Grievances & Appeals	33	3
Long-Term Services and Support (LTSS) CM	74	4
Pharmacy	18	2
Provider Network	61	13
Quality	49	13
Utilization Management (UM)	66	4
Total	**442**	**48**

Mercer would like to recognize [redacted] for its timely response to the request for information, as well as its open exchange of information during the virtual onsite visit. The following represents the key strengths and areas of opportunity noted during the three-day evaluation process.

Strengths

- [redacted] demonstrated assertive outreach and support during the Novel Coronavirus Disease (COVID-19) pandemic and has begun the process of reinstating community-based face-to-face CC visits, including visits with incarcerated members. [redacted] focus on associate well-being was also viewed as integral to ensuring ongoing operations throughout the remainder of 2020. This focus enabled [redacted] staff to be consistently available and focused on member needs.

- [redacted] initiated a cross matrix collaborative titled the Medicaid Book Club, which is a series of Medicaid and [redacted] 101 training series that incorporate adult learner strategies and seeks to educate [redacted] staff with both federal and State Medicaid requirements, fusing the day-to-day job role with broader understanding of why that role is important.
- [redacted] exhibited strong oversight and auditing processes and utilized case file findings to address individual and systemic issues throughout the care coordination and case management programs.
- [redacted] has developed a plan for implementing the Coleman Discharge Planning Model in an effort to improve discharge and transition supports to members with complex needs and has developed a workgroup to address missed hours and gaps in care for private duty nursing and all other services.
- [redacted] worked collaboratively with [redacted] and [redacted] to stand up a new Adult Dental program quickly and effectively.
- [redacted] innovative Opioid pod program continues to improve by engaging in weekly provider training; including reporting on provider-specific prescribing patterns. [redacted] also implemented a Point of Sale edit to alert dispensing pharmacies to recommend [redacted]® for members that are on high-dose opioids.

Opportunities

- [redacted] should identify the required Staff Training Coordinator and develop a document outlining the role and responsibilities of this position and addressing how this role may interact with department directors, supervisors, and managers to ensure the training program is executed. This would aid in the fulfilling ongoing training needs of [redacted] such as developing training and tools for call center staff to help them be more efficient and effective in call resolution.
- Infusion of quality throughout the organization must be a priority for [redacted]. While there has been some preliminary evidence of improvement throughout 2020, a number of opportunities exist. Participation by departmental leads was lacking for most of 2020 in the Quality Improvement/Utilization Management (QI/UM) committee. The committee meeting notes indicate a significant number of committee members, many of whom did not participate in the meetings in over one year. In addition to participation in the committee, there should be robust engagement of departmental leads within PIPs and other QI initiatives.
- Preventing, detecting, and remediating critical incidents (CIs) to ensure the safety and well-being of [redacted] members is vital. Throughout 2020, the MCO was in the process of developing interventions and enhancements; however, the interventions and enhancements were focused almost exclusively on the role of the care coordinator/case manager. [redacted] should update and refine the workflow for management of CIs to indicate identification of a CI may occur by anyone, not exclusively a care coordinator/case manager. The quality program

evaluation included tracking/trending analysis of CIs, but the policy for quarterly and annual evaluation does not include CIs. Quarterly tracking/trending of CIs would serve as an early warning for [redacted].

- The MCO generates reports that are submitted to the State that are based on provider practice analysis. However, there is not a standing meeting or review of these reports by the peer review committee to assess the quality of care by providers. The MCO provided a description of the provider corrective action plan (CAP) process based on formal peer review. However, there may be instances, based on provider practice analysis (not rising to the level of formal peer review), that result in the need for a CAP. This process is not documented and was not described as a standard process. The MCO states that the goal of provider practice analysis is to evaluate the quality of care and services rendered in order to identify opportunities where [redacted] and the provider can work together to improve the health care of members. However, this process to review the provider practice analysis and develop policy recommendations based on the results is not documented and was not described as a standard process.

- An adequate provider network is key to delivering care to members. To more fully evaluate network adequacy and capacity, [redacted] should incorporate additional information, such as missed and late visit reports and alternative service wait times into the Provider Network Development and Management Plan. Additionally, the External Quality Review Organization encourages [redacted] to fully implement its CAP and to develop an overarching, end-to-end policy that addresses provider terminations, inclusive of the role that delegate provider roster exchanges play in the process, addressing the role and responsibility of each entity and business unit, and the process used to ensure ongoing compliance and quality assurance.

- All contractual expectations flow to any entity to whom activities have been delegated; therefore, oversight by [redacted] of these delegates is critical. Vendor management oversight policies outlining delegation oversight were submitted, but some documents were still marked draft and [redacted] could not consistently identify what services were delegated to a certain vendor. [redacted] should be able to readily identify all delegates, the delegates' responsibilities and should review their P&Ps around oversight of delegated or subcontracted entities. The MCO does not have a tool or process to evaluate the compliance of its delegates responsible for adjudication of a grievance and/or appeals. The MCO needs to develop a process and tools for structured oversight of delegated grievance and appeals activities.

- There is a need for the MCO to continue its efforts specific to member case file audits in order to continue to drive improvements regarding assessment, care planning, follow-up on identified member needs (including preventive care), and to ensure appropriate standards of documentation, including documentation of late entries made in member records. The MCO needs to develop a policy, based on generally accepted medical record documentation standards, to provide guidance for late entries made in member records.

- The MCO has formalized the use of evidence-based disease management standards for CCC and is working to reduce care coordinator ratios below the required level in order to allow care coordinators more time to address the needs of complex members. The MCO needs to continue its efforts to audit member files to ensure care coordinators are consistently utilizing disease management standards and to ensure member case files reflect appropriate assessment, care planning, follow-up to identified member needs, and documentation

standards. There were missed opportunities to outreach hospitalized members. There is a recurrent issue of needs being identified on the initial call and then subsequent efforts to engage or reach the member are unsuccessful, leaving needs unaddressed. The MCO may benefit from ensuring assistance is offered during the initial touch point to engage the member. Stratification was an issue in most of the cases reviewed. Many of the Level 1 cases were quite complex and could have benefited from a referral to Level 2. While some cases were restratified numerous times, there was not any reference to previous outreach attempts or member participation/declination. The MCO recently revised its risk stratification plan and methodology where the majority of revisions are in compliance with contract standards; however, the MCO needs to address gaps in the approach to risk stratification for members being discharged from inpatient physical health (PH) and behavioral health (BH) stays to ensure assignment to Level 2 CC when appropriate. Provide evidence, based on focused audits of resource coordination member records, demonstrating fidelity to the process for ensuring members being discharged from inpatient PH and BH admissions are assigned to the appropriate level of CC.

- The majority of PIP interventions implemented over the past several years, including 2020, have been passive in nature (e.g., newsletter articles, mailings, etc.), which have not resulted in the improvement intended with PIPs. The MCO must take a more aggressive approach to developing innovative interventions that show active engagement with members and community partners. At the time of the review in 2021, the EQRO and [redacted] are cautiously optimistic that [redacted] now has the resources and team to focus efforts particularly as it relates to PIP. Specifically, the Manager of QI, Regulatory, and Accreditation exhibited a strong base knowledge to identify PIP topics, develop an appropriate question, select quantifiable lead and lag measures, and implement and assess interventions all of which are supported by enhanced analytics.

- Given the vast number of the reports, changes within the health care industry as well as changes within the [redacted] organization, developing a robust process of data governance, as noted during the Information Systems Capabilities Assessment, could greatly benefit the MCO operation. For consistency, each data element used in the reporting should have clear definitions, acceptable values domains, a clear owner, and defined purpose and use. Additionally, on a regular basis (e.g., annually) all reports and data elements should be reviewed to ensure no changes are required to the reporting such as adding new CPT codes, provider taxonomies, and other health care nomenclature. Moreover, the review of the reports would allow [redacted] to determine if any changes based on the system changes (i.e., upgrades and enhancements) necessitate report modifications to account for these transformations.

5

2 Introduction

Mercer Government Human Services Consulting (Mercer) conducted an external quality review (EQR) of [redacted] at the request of the [redacted] (or State), [redacted], in accordance with 42 CFR Part 438, Subpart E. During this annual EQR cycle, a managed care organization (MCO) comprehensive review was conducted with [redacted]. The content of the EQR included the following areas:

- Comprehensive compliance review of [redacted] with Federal Regulations for Medicaid Managed Care (FRMMC) and State standards.
- Compliance with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).
- Compliance with contract standards for:
  - Diamond State Health Plan (DSHP) Plus case management (CM).
  - DSHP All Member Level Care Coordination (CC), Level 1 Resource Coordination, and Level 2 Clinical Care Coordination (CCC).
- Performance improvement project (PIP) assessment.
- Performance measure (PM) assessment.

The purpose of this independent review was to:

- Assess compliance with all federal regulations pertaining to Medicaid and Children's Health Insurance Program (CHIP) managed care programs in 42 CFR part 438 and 42 CFR part 457, respectively, and state-defined standards.
- Assess the ability of [redacted] and its programs to achieve quality outcomes and timely access to health care services for Medicaid, CHIP, and DSHP Plus members enrolled in [redacted] and covered under its contract with [redacted].
- Review the consistency of [redacted] internal policies, procedures, and processes.

To complete this review, Mercer applied FRMMC, CHIPRA, and State regulations, contractual requirements, [redacted] internal policies and procedures (P&Ps), and state-defined standards communicated to the MCO through its managed care contract and the Medicaid/CHIP/DSHP Plus Quality Management (QM) Strategy.

To kick off the EQR, Mercer developed a timeline that chronologically summarized the EQR deliverables and their due dates for 2021 and distributed it to [redacted] staff. The 2021 comprehensive compliance review encompassed the MCO's calendar year 2021 operations and specifically focused the file review on the period of July 1, 2020 through December 31, 2020. The 2021 EQR process began on May 17, 2021, when Mercer delivered the request for information (RFI) to [redacted]. Mercer used a Health Insurance Portability & Accountability Act (HIPAA) compliant secure file transfer protocol site, SharePoint, to allow a secure exchange of information among Mercer, [redacted], and the MCO. MCO materials were uploaded to the SharePoint site by June 7, 2021. The desk review was a comprehensive analysis of P&Ps and supporting documents related to FRMMC, CHIPRA, and State contract standards. In addition, Mercer reviewed the CC, CM, provider and organizational provider credentialing/recredentialing, provider termination, pharmacy prior authorization (PA), and grievance and appeal files and submitted preliminary findings to [redacted] to prepare for the onsite review.

Due to the public health emergency (PHE) declared January 31, 2020 (i.e., the Novel Coronavirus Disease [COVID-19]) the onsite portion of the annual compliance review was conducted virtually via video conference and teleconference. The annual virtual onsite review was conducted by Mercer, with [redacted] staff in attendance, on August 10, 2021–August 12, 2021. The documentation reviews and staff interviews were conducted to gain a more complete and accurate understanding of the operations of [redacted] and how those operations contribute to its compliance with federal and State regulations and requirements, consistency with internal P&Ps and processes, and adherence to contractual standards in the provision of health care services to its enrollees.

Mercer would like to recognize [redacted] for its timely response to the RFI, as well as its open exchange of information during the review. In the particularly challenging virtual onsite review environment, [redacted] exhibited robust staff and leadership participation as well as flexibility for accommodating the review team's needs.

The following represents the key strengths and areas of opportunity noted during the three-day evaluation process.

Strengths

- [redacted] demonstrated assertive outreach and support during the Novel Coronavirus Disease (COVID-19) pandemic and has begun the process of reinstating community-based face-to-face CC visits, including visits with incarcerated members. [redacted] focus on associate

well-being was also viewed as integral to ensuring ongoing operations throughout the remainder of 2020. This focus enabled [redacted] staff to be consistently available and focused on member needs.

- [redacted] initiated a cross matrix collaborative titled the Medicaid Book Club, which is a series of Medicaid and [redacted] 101 training series that incorporate adult learner strategies and seeks to educate [redacted] staff with both federal and State Medicaid requirements, fusing the day-to-day job role with broader understanding of why that role is important.
- [redacted] exhibited strong oversight and auditing processes and utilized case file findings to address individual and systemic issues throughout the care coordination and case management programs.
- [redacted] has developed a plan for implementing the Coleman Discharge Planning Model in an effort to improve discharge and transition supports to members with complex needs and has developed a workgroup to address missed hours and gaps in care for private duty nursing and all other services.
- [redacted] worked collaboratively with [redacted] and [redacted] to stand up a new Adult Dental program quickly and effectively.
- [redacted] innovative Opioid pod program continues to improve by engaging in weekly provider training; including reporting on provider-specific prescribing patterns. [redacted] also implemented a Point of Sale edit to alert dispensing pharmacies to recommend [redacted]® for members that are on high-dose opioids.

Opportunities

- [redacted] should identify the required Staff Training Coordinator and develop a document outlining the role and responsibilities of this position and addressing how this role may interact with department directors, supervisors, and managers to ensure the training program is executed. This would aid in the fulfilling ongoing training needs of [redacted] such as developing training and tools for call center staff to help them be more efficient and effective in call resolution.
- Infusion of quality throughout the organization must be a priority for [redacted]. While there has been some preliminary evidence of improvement throughout 2020, a number of opportunities exist. Participation by departmental leads was lacking for most of 2020 in the Quality Improvement/Utilization Management (QI/UM) committee. The committee meeting notes indicate a significant number of committee members, many of whom did not participate in the meetings in over one year. In addition to participation in the committee, there should be robust engagement of departmental leads within PIPs and other QI initiatives.
- Preventing, detecting, and remediating critical incidents (CIs) to ensure the safety and well-being of [redacted] members is vital. Throughout 2020, the MCO was in the process of developing interventions and enhancements; however, the interventions and enhancements were

focused almost exclusively on the role of the care coordinator/case manager. [redacted] should update and refine the workflow for management of CIs to indicate identification of a CI may occur by anyone, not exclusively a care coordinator/case manager. The quality program evaluation included tracking/trending analysis of CIs, but the policy for quarterly and annual evaluation does not include CIs. Quarterly tracking/trending of CIs would serve as an early warning for [redacted].

- The MCO generates reports that are submitted to the State that are based on provider practice analysis. However, there is not a standing meeting or review of these reports by the peer review committee to assess the quality of care by providers. The MCO provided a description of the provider corrective action plan (CAP) process based on formal peer review. However, there may be instances, based on provider practice analysis (not rising to the level of formal peer review), that result in the need for a CAP. This process is not documented and was not described as a standard process. The MCO states that the goal of provider practice analysis is to evaluate the quality of care and services rendered in order to identify opportunities where [redacted] and the provider can work together to improve the health care of members. However, this process to review the provider practice analysis and develop policy recommendations based on the results is not documented and was not described as a standard process.

- An adequate provider network is key to delivering care to members. To more fully evaluate network adequacy and capacity, [redacted] should incorporate additional information, such as missed and late visit reports and alternative service wait times into the Provider Network Development and Management Plan (PNDMP). Additionally, the External Quality Review Organization (EQRO) encourages [redacted] to fully implement its CAP and to develop an overarching, end-to-end policy that addresses provider terminations, inclusive of the role that delegate provider roster exchanges play in the process, addressing the role and responsibility of each entity and business unit, and the process used to ensure ongoing compliance and quality assurance.

- All contractual expectations flow to any entity to whom activities have been delegated; therefore, oversight by [redacted] of these delegates is critical. Vendor management oversight policies outlining delegation oversight were submitted, but some documents were still marked draft and [redacted] could not consistently identify what services were delegated to a certain vendor. [redacted] should be able to readily identify all delegates, the delegates' responsibilities and should review their P&Ps around oversight of delegated or subcontracted entities. The MCO does not have a tool or process to evaluate the compliance of its delegates responsible for adjudication of a grievance and/or appeals. The MCO needs to develop a process and tools for structured oversight of delegated grievance and appeals activities.

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continue its efforts to audit member files to ensure care coordinators are consistently utilizing disease management standards and to ensure member case files reflect appropriate assessment, care planning, follow-up to identified member needs, and documentation standards. There were missed opportunities to outreach hospitalized members. There is a recurrent issue of needs being identified on the initial call and then subsequent efforts to engage or reach the member are unsuccessful, leaving needs unaddressed. The MCO may benefit from ensuring assistance is offered during the initial touch point to engage the member. Stratification was an issue in most of the cases reviewed. Many of the Level 1 cases were quite complex and could have benefited from a referral to Level 2. While some cases were restratified numerous times, there was not any reference to previous outreach attempts or member participation/declination. The MCO recently revised its risk stratification plan and methodology where the majority of revisions are in compliance with contract standards; however, the MCO needs to address gaps in the approach to risk stratification for members being discharged from inpatient physical health (PH) and behavioral health (BH) stays to ensure assignment to Level 2 CC when appropriate. Provide evidence, based on focused audits of resource coordination member records, demonstrating fidelity to the process for ensuring members being discharged from inpatient PH and BH admissions are assigned to the appropriate level of CC.

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3

Methodology

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 used the MCO RFI, based on the Centers for Medicare & Medicaid Services (CMS) protocol and modified by Mercer to meet the needs of [redacted], to acquire information specific for all areas of the review. Examples of information requested included P&Ps, quality, utilization management (UM), and CM program descriptions, enrollee and provider documents, copies of meeting minutes, and evidence to support PIPs and PMs. The RFI also requested file logs to facilitate file selection.

Desk 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 onsite review phase, additional information was collected; a small number of outstanding data needs remained. At the close of the virtual onsite review process, the outstanding information needs were summarized and submitted to Mercer for further review and consideration following the virtual onsite visit.

An EQR compliance review tool (tool) adapted from CMS protocols was utilized for the compliance section of the review. The tool was designed to include State standards reflecting key issues and priorities of [redacted]. The tool assisted the reviewers in coordinating the review process in a logical manner, consistent with the flow of the regulations at 42 CFR Part 438 and 42 CFR Part 457 Subpart L regulations (Final Rule). Mercer's desk review results helped to focus observations and interviews to gather additional information during the virtual onsite review.

File Review Protocol

Similar to the RFI, Mercer developed a file request Excel template containing the specific date range and data fields required for each of the file review areas. Additionally, Mercer provided the detail file formats and content expected for each file review type. These templates were shared with [redacted] via the SharePoint site.

In selecting the files to be evaluated, Mercer utilized the National Committee for Quality Assurance's (NCQA's) "8/30" rule for evaluation of health care organization file reviews. The rule states that of a sample of 30 files, if the initial eight pass the review, the entire sample of 30 can be cleared. The additional 22 files are reviewed if and only if issues are discovered in the first eight. The NCQA has evaluated this method to be "a cost effective and statistically appropriate method of gathering data about the overall performance" of a health care organization. After discussion with [redacted] for the purpose of all file reviews, Mercer employed a variant of the "8/30" rule, and chose to review 10 files selected from a sample of 30. For file reviews in which there was not enough volume to reach the 10 or 30 file denominator, Mercer reviewed all files for that category.

After receiving the universe file listing for the specified time period, Mercer selected a targeted random sample of files for review. The final file selection was distributed to the MCO via the SharePoint site, and the MCO was provided two weeks to upload the file contents to the SharePoint site. Mercer reviewed the files and posted the preliminary file findings prior to the virtual onsite review to allow the MCO an opportunity to collect additional information to address file findings. Outstanding file findings were discussed during the virtual onsite review; additional supporting documentation was requested and provided as available.

For scoring the file review, Mercer has retained a 3-tiered system. This approach for quantitative scoring was determined as more appropriate than a 5-tiered system due to predictive constraints of the denominator size.

File Review Compliance Level Definitions	
Met	For file reviews, the MCO must have achieved 90% compliance or greater.
Partially Met	For file reviews that scored between 75% and 89% compliance.
Not Met	For file reviews that scored less than 75% compliance.

Virtual Onsite Review

As noted previously, due to the COVID-19 PHE, the onsite portion of the annual compliance review was conducted virtually. The virtual onsite review took place over a three-day period, utilizing web-based video and telephonic technology to link the EQRO, [redacted], and [redacted] participants. The virtual onsite review began with an introductory session, with Mercer, [redacted] representatives and appropriate [redacted] staff in attendance. The specific flow of the virtual onsite review and personnel in attendance during the three-day review can be found in Appendix A.

Analysis and Reporting

Information from all phases of the review process was gathered, and a comprehensive analysis was completed. The following report sections present the topics reviewed, the [redacted] team members who participated in the review, as well as the metrics requiring a corrective action plan (CAP) as a result of the 2021 review (i.e., substantially met, partially met, minimally met, not met). Appendix B contains a comprehensive description of federal Medicaid managed care and State contractual requirements reviewed, review findings (met, substantially met, partially met, minimally met and not met), and recommendations requiring CAPs. Results of this analysis make up this report and are written in a format consistent with federal protocols to easily identify compliance with the Final Rule. The table below outlines the thresholds utilized to determine compliance findings.

Compliance Level Definitions	
Met	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.
Substantially Met	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.

Compliance Level Definitions	
Partially Met	MCO staff describes and verifies the existence of compliant practices during the interview(s), but required documentation is incomplete or inconsistent with practice.
Minimally Met	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.
Not Met	No documentation is present and MCO staff have little to no knowledge of processes or issues that comply with regulatory or contractual provisions.

In following the sequence of events described in this report section, Mercer complied with CMS regulations to conduct the EQR in a logical fashion that assisted in identifying [redacted] overall performance and its compliance with federal and State rules and regulations. Throughout the virtual onsite process, participants in the interview group were adjusted to include representatives from various departments, as required, to address issues and reflect the flow of processes conducted by various departments in delivering information, education, and health care services to their Medicaid, CHIP, and DSHP Plus enrollees.

4

Organization and Operational Structure

Historical Overview

[redacted]

With the declaration of the PHE in March 2020, [redacted] had to transition all office-based staff to a remote, work-at-home model. To support staff in the transition and during the ensuing months, [redacted] leadership enhanced communication forums with staff members, and developed new forums and innovations to improve communications while still assisting associates affected by the PHE. Members are best supported when those that they interface with are present, engaged, and utilizing critical thinking. [redacted] focus on associate well-being is viewed as integral to

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ensuring ongoing operations throughout the remainder of 2020. This focus enabled [redacted] staff to be consistently available and focused on member needs.

Organizational Structure

[redacted]

The following table provides an overview of the individual entities comprising [redacted] and their respective responsibilities:

Entity	Responsibilities
[redacted]	• Oversight of all Operations • Program Management and Administration • UM (Physical Health [PH], Behavioral Health [BH], and Long-Term Services and Support [LTSS]) • Rapid Response • CC (PH and BH) • CM (LTSS) • QM and Performance Improvement • Member Advocacy • Member Engagement and Communication • Community Health Navigators • Provider Network Management, Operations (including vendors) and Provider Communication • Appeals and Grievances • Program Integrity (fraud, waste, and abuse)

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Entity	Responsibilities
[redacted]	• Eligibility and Enrollment • Claims Processing and Payment • Encounter Data Management • Member and Provider Call Center
[redacted]	• Provider Information Management • Credentialing/Recredentialing • Finance • Human Resources • Legal Affairs • Privacy • Audit and Compliance • NCQA Accreditation
[redacted]	• Pharmacy Services and Benefit Management

Organizational Goals

In its fifth year of operation, [redacted] marked the year by creating the [redacted] and [redacted] to help enable the transition of its services from [redacted] to [redacted]. Internal service stabilization and closure of outstanding CAPs were a top focus throughout 2020. This focus continues into 2021 as [redacted] advances its internal transformation efforts by planning to implement a new clinical system as well as focusing on improving employee engagement. Declaration of the PHE resulted in a rapid transition of office-based staff to a new remote work environment, coordination of messaging to network providers on a myriad of topics, and a focus on how to continue to serve members and ensure services were available.

Overall Assessment

There was a number of new individuals hired into key personnel roles in 2019; staffing of key personnel has remained stable throughout 2020. Declaration of the PHE and rapid shift of staff to a work-at-home model along with suspension of face-to-face contact for members and

providers stress-tested [redacted] leadership and MCO staff. [redacted] expanded its staffing complement, assuming greater responsibility, as it shifted services from [redacted] to [redacted]. While [redacted]'s structure is highly matrixed, it is clear that all levels of staff are working collaboratively to streamline operations, identify efficiencies, and implement best practices. During the interview sessions, discussions that crossed a number of different business units and operating entities highlighted the connection of leadership, directors, and managers to frontline work processes. [redacted] has undertaken significant transformation efforts and continues to focus on service excellence and harnessing technology to improve not only its service delivery but to enhance its focus on member outcomes. The PHE and pivot to remote work environments resulted in new approaches allowing [redacted] to continue to hire and onboard new staff members in a remote environment while maintaining existing operations. The resiliency of [redacted] and its staff during this time is a testament to [redacted]'s leadership team, its engagement, and support of [redacted] staff members.

While the EQRO identified the above opportunities, [redacted] demonstrated significant process improvements, strengths, and a training "best practice" as highlighted below.

- Development of Medicaid and [redacted] [redacted] 101 training series that incorporates adult learner strategies and seeks to educate [redacted] staff with both federal and State Medicaid requirements, fusing the day-to-day job role with broader understanding of why that role is important.
- Striving for continuous quality improvement (CQI) by ensuring high-level cross-collaboration between business units within [redacted] and across its operating entities. Where heavily matrixed environments can often lead to silos and poor communication linkages, throughout the three-day interview sessions the level of engagement, ownership, and shared vision for today and the future was evident and demonstrated an organizational culture focused on CQI and "getting it right".

Throughout 2020, [redacted] prepared for its NCQA audit scheduled for June 2021 and successfully received NCQA's "*Accredited*" designation. Continuing maintenance of effort on prior CAP remediation activities was evidenced as [redacted] has continued to focus on regulatory compliance as one of its primary goals. However, several corrective actions remain ongoing throughout 2020 including the development of an appropriate provider termination process that ensured service continuation and opportunity to locate and select new primary and specialty providers.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has a process to ensure contract requirements regarding key staff: • The MCO will notify the State within seven calendar days of change in key personnel. (3.20.1.3) • Key personnel will not be reassigned by the MCO to another project without prior written consent of the State. (3.20.1.4) • Key personnel will be replaced within 90 calendar days of a vacancy, proposed candidates will be subject to State approval, and the State approves key personnel hires. (3.20.1.5) • Key personnel will be located in [redacted]. (3.20.1.9)	Substantially Met	[redacted] has placed very specific requirements on key personnel, which requires tracking timelines, seeking approval from the State, and obtaining written consent from the State when certain circumstances arise. [redacted] does not currently have a policy or desk level procedure capturing these requirements nor does it identify the party responsible for ensuring compliance with contract requirements.	Create a policy or desk level procedure that outlines the process, responsible party, and mechanisms to ensure compliance with key personnel requirements stated in citation 3.20 of the Master Services Agreement (MSA).
The MCO has an initial and annual training plan. The plan details the frequency and topics included in training (at a minimum covering items in 3.20.3.5) and the process for evaluating the effectiveness and outcomes of the training provided. The plan includes specific training for the DSHP Plus LTSS CM staff and Program Integrity for all MCO staff. The MCO has a staff training coordinator. (3.20.3.4)	Substantially Met	[redacted] has developed a comprehensive training program outlining the program from the corporate entity down to the business unit/functional area. Additionally, [redacted] developed and implemented new trainings focused on Medicaid and [redacted]-specific [redacted] requirements for all staff. The Staff Training Coordinator and the responsibilities, for the entirety of [redacted], attached to that contractually required role have not been identified or developed.	Identify the required Staff Training Coordinator and develop a document outlining the role and responsibility of this position and address how this role may interact with department directors, supervisors, and managers to ensure the training program is executed.

[redacted]

5

Compliance with Federal Regulations for Medicaid Managed Care and State Standards — Enrollee Rights and Protections

Information Requirements, Benefit Information, Marketing, and Emergency and Post-Stabilization Services

The following federal regulation is addressed in this section: 438.100 (a) (1–2).

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 (b), 438.10 (d), and 438.102.

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: 438.10 (f), 431.51, 438.10 (g) (3), 438.10 (h), 438.106, and 438.108.

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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 provides the enrollee with information, including enrollee rights, scope of benefits, changes to member benefits, provider terminations, limitations of freedom of choice of providers, and financial considerations.

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.

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.

To evaluate [redacted]'s compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of [redacted]'s RFI response, consisting of policies, procedures, and supporting documentation, including the Member Handbook, Provider Manual, contract templates, letter templates, and [redacted]'s member website. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite meetings held August 10, 2021–August 12, 2021. The virtual onsite meetings involved key leadership from the MCO including but not limited to:

- Senior Vice President (SVP), Medicaid Markets
- Vice President (VP), [redacted] Markets, Chief Executive Officer (CEO)
- VP, Operations, Chief Operations Officer (COO)
- VP, Medicaid Business Management
- VP, Medicaid Service Operations
- VP, Medicaid Business Solutions
- VP, Finance, Chief Financial Officer (CFO) [redacted]

- Director, Provider Experience
- Director, Member Experience
- Director, Payment Integrity
- Director, Enrollment and Billing
- Director, Product Compliance and Innovation
- Director, Analytics
- Director, IT
- Manager, Grievances and Appeals
- Manager, Vendor Management

Overall Assessment

Member Rights, Responsibilities, and Member Communication Requirements

Enrollee rights are published in the Member Handbook, Provider Manual, and on [redacted]'s member portal. Members are advised of their rights and responsibilities (R&Rs) upon enrollment and annually. Upon enrollment, the member is mailed a new member welcome letter, which details instructions on accessing the member portal as well as the Member Handbook, both of which house the member's R&Rs. The welcome letter includes information on how a member can receive a copy of the handbook via mail or request an alternate version of the handbook at no charge by contacting Member Services at their toll-free number. Staff members are educated about enrollee rights as part of new hire orientation; training emphasizes the requirements found in Section 1557 of the Patient Protection and Affordable Care Act, which outlines the nondiscrimination provisions prohibiting discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Corporate P&Ps globally address member R&Rs and specifically address member requests for access to health records and the right to change information including instances where access to and the right to change are denied along with due process and grievance pathways. Delegates, through contract, are required to follow all [redacted] contract requirements; when necessary and appropriate [redacted] works with its delegates to provide training on key topics pertinent to the [redacted] contract.

Information regarding enrollee rights and protections, available benefits, telemedicine, and how to access emergency care are all contained within the Member Handbook, which is made available in English and Spanish for both the DSHP/[redacted] and DSHP Plus populations. Alternative formats of the Member Handbook, including braille, audio CD, TTY, and language translation services (including American Sign Language) are available to members at no cost. Members are advised, via the Member Handbook and [redacted] website, to contact Member Services via [redacted]'s toll-free number to request translation assistance. [redacted] indicated the Member Advocate can also provide assistance to the member in accessing these services or in accompanying the member to the provider's office.

A full list of covered benefits, including those not covered by [redacted], are available within the Member Handbook, which is accessible online via [redacted]'s website. Information on the types of conditions that constitute an emergency and how to access emergency services versus when to use urgent or primary care is shared via the Member Handbook and is also posted online. The handbook addresses all contractually required elements. All P&Ps are consistent with federal regulations and contractual requirements.

Member call center operations continue to be handled out of the [redacted] contact center and real-time monitoring of member calls is available from the [redacted] office location. During the virtual onsite review, Mercer and [redacted] staff listened in to four member calls. Member services operations were smooth and evidenced happy, customer-centric staff dedicated to assisting members to the best of their ability. While call center staff demonstrated exemplary customer service skills, there were opportunities for [redacted] to provide training and tools to call center staff to help them be more efficient and effective in call resolution. Below are several examples that demonstrate missed opportunities for [redacted]'s call center.

- One member called inquiring about his medication and how he was in step therapy but now wanted to move past this and receive his brand name medication. The member stated that he was calling from outside of an outpatient facility. Although the call center representative was kind and compassionate, the representative did not follow operational procedure to utilize all available resources (i.e., outreach to the Assist line, SharePoint site, etc.) to be able to assist the member appropriately. The representative did not reach out to Pharmacy for the medication issue nor did they outreach out to CC. During the virtual onsite, Mercer asked for a follow-up case summary of this member. After reading through the case summary, it was evident that this was a member that [redacted] had difficulty reaching. It also became clear that [redacted] did not have any mechanisms for identifying whether a member is engaged in CC/CM nor any mechanisms to indicate that the MCO had been trying unsuccessfully to engage with the member. This type of alert would have allowed a “lost to contact” member to be re-engaged.

- In another example, a member called requesting to change her primary care provider (PCP). While on the call the member stated she had knee problems as well as bad teeth. Although, the call center representative was kind and compassionate, the representative did not follow operational procedure to utilize all available resources (i.e., outreach to the Assist line, SharePoint site, etc.) to be able to assist the member appropriately. During the virtual onsite, Mercer asked for a follow-up case summary of this member. After reading the case

summary, the member had a substance use disorder (SUD) diagnosis and at no time during the call was the member referred to CC nor was the member asked the reason for the change in PCP nor if they wanted to file a grievance. During Mercer's onsite interview, it was learned that [redacted] does not have flags in their system for gaps in care, which was needed in this case. Similar to the above case, an indicator that the MCO was trying to engage this member would have helped to re-engage a "lost to contact" member.

Emergency and Post-Stabilization Services

[redacted] offers definitions of emergency and post-stabilization services, which are consistent with federal rules and State contract requirements and does not limit an emergency condition by diagnosis or symptom. These definitions are found within P&Ps, as well as in the Member Handbook. Education about what constitutes an emergency versus an urgent care need are defined in member materials. Policies authorizing payment for post-stabilization services reflect federal definitions and cover care provided in- and out-of-network (OON), and respects that it is the treating physician who determines whether the member is stable for transfer to in-network providers.

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.

Marketing

[redacted] maintains a [redacted]-specific policy governing the development, production, and distribution of marketing materials for members, which, meets federal requirements pertaining to member communications including the availability of materials in alternative formats including braille. Additionally, [redacted] creates an annual marketing plan, in accordance with its contract requirements with the State. The annual plan is submitted to [redacted] for review and approval at the beginning of each year, as are all member facing wellness and marketing materials. Given the PHE that dominated most of 2020, [redacted] focused its attention on marketing on the run up to the open enrollment period that occurs later in the year. Billboards, bus stop advertisements, and social media marketing campaigns focused on attracting new members, as well as encouraging existing members to stay with [redacted].

[redacted]'s approach to development and distribution of marketing materials includes methods to ensure quality control, as well as ensure material is accurate, does not mislead, confuse, or defraud a member or the State. The State requires that the MCO disclose events and activities [redacted] plans to sponsor and/or participate in during the year; the annual budget for sponsorship cannot exceed a pre-determined threshold set by the State. [redacted] continued to expand its digital footprint beyond Facebook and Instagram to incorporating a strategy to include Twitter in the dissemination of [redacted] approved health plan information and wellness messages, as well as information regarding [redacted] and community events and resources.

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.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The call center: • Has the capacity to monitor calls remotely. (3.14.2.3.3) • Can receive calls from limited English proficiency and hearing impaired callers. (3.14.2.3.4) • Has bilingual Spanish (and other prevalent language) representatives. (3.14.2.3.5) • Must allow members to first choose their preferred language on the phone line. (3.14.2.3.6) • Is staffed at least Monday through Friday, 8:00 am to 7:00 pm eastern, except for holidays, and has an automatic system to handle calls outside of business hours. (3.14.2.3.7 and 3.14.2.3.13) • Staff must be trained to respond to member questions on DSHP and DSHP Plus as described in 3.14.2.3.8. • Has procedures to transfer calls appropriately and warm transfer when required. (3.14.2.3.10, 3.14.2.3.11) • Has access to electronic documentation from previous calls from the member services line, nurse triage/advice line, pharmacy service information line, care coordination and case management. (3.14.2.3.14)	Substantially Met	The MCO's call center operations meet requirements with extensive P&Ps, capacity to monitor calls remotely, staffing hours, etc. Evidenced through member calls, customer service representatives (CSRs) demonstrated friendly dispositions and engagement with members but had unrecognized opportunities to resolve the member's issue and get the member the appropriate care needed. • The CSR did not follow operational procedure to utilize all available resources (i.e., outreach to the Assist line, SharePoint site, etc.) and transfer the member to the appropriate person (e.g., pharmacy, care coordinator, etc.). • [redacted]'s system did not show evidence that mechanisms for identifying members in CC/CM were present for the CSR to view nor were there mechanisms in the system to identify that MCO was trying to engage with this "lost to contact" member. • [redacted]'s system did not show evidence that it alerts the CSRs	Provide evidence of CSR training to follow internal P&Ps for utilizing all resources as well as warm transferring members to appropriate departments to resolve care issues. Implement a system that allows the CSR to quickly identify members who are engaged in CC/CM or who the MCO is trying to engage and/or were engaged in CC/CM but "lost to contact". Implement a system that allows the CSR to identify gaps in care, address those gaps, and offer assistance while the member is on the line.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
• Has the ability to access the wellness registry to help link members to covered and non-covered services. (3.6.2.9.4.1.2)		when there are gaps in care for the members on the phone.	

Advance Directives

The following federal regulations are addressed in this section: 438.100 (b) (2) (iv), 438.6 (i) (2), 422.128, and 417.436 (d).

The intent of these regulations is to ensure the MCO maintains P&Ps related to advance directives (ADs), including their rights under State law, and must contain clear and concise language on the limitation if the MCO cannot implement an AD as a matter of conscience. The MCO is responsible for providing enrollees with periodic written information regarding ADs and their rights under the State laws. The MCO is expected to provide education for staff, providers, and the community regarding ADs.

To evaluate [redacted]'s compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of [redacted]'s RFI response, consisting of policies, procedures, and supporting documentation including the Member Handbook, member newsletters, CM systems, and [redacted]'s member website. This review was conducted based on information submitted by [redacted] through the RFI and onsite meetings on August 10, 2021–August 12, 2021. The onsite meeting included key leadership from the MCO including but not limited to:

- SVP, Medicaid Markets
- VP, [redacted] Markets, CEO
- VP, Operations, COO
- VP, Medicaid Business Management
- VP, Medicaid Service Operations
- VP, Medicaid Business Solutions
- VP, Finance, CFO [redacted]

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- Director, Provider Experience
- Director, Member Experience
- Director, Payment Integrity
- Manager, Grievances and Appeals

Overall Assessment

[redacted] meets the federal regulations and contract requirements for notification to adult members regarding their rights under State law relative to ADs. In addition to new member orientation, newsletter articles and the Member Handbook, [redacted]'s website provides the appropriate link to the [redacted] approved AD form, retrievable from the Division of Services for Aging and Adults with Physical Disabilities website. [redacted] encourages members to contact Member Services for AD forms. Case managers and care coordinators have been trained to provide assistance to members and/or families and caregivers who have questions about ADs. Training on ADs for [redacted]s care coordinators and/or case managers occurs upon hire and annually thereafter, emphasizing the importance of speaking with members about ADs. These care coordinators and/or case managers work directly with members, their families, and caregivers to provide education on this topic as well as collect completed ADs.

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.

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Compliance with Federal Regulations for Medicaid Managed Care and State Standards — Quality Assessment and Performance Improvement

Quality Assessment and Performance Improvement Program

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.

To evaluate [redacted]'s quality assessment and performance improvement, Mercer conducted a thorough review of [redacted]'s RFI response, consisting of policies, procedures, and supporting documentation including information on the QM department, the Quality committee structure, the 2020 program evaluation, and the 2021 QM program description and compliance approach. This review was conducted based on information submitted by [redacted] through the RFI and onsite meetings on August 10, 2021–August 12, 2021. The onsite meetings included key leadership from the MCO including but not limited to:

- Chief Medical Officer (CMO)

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2021 External Quality Review [redacted]

[redacted]

- Director, Quality
- Director, Analytics
- Director, LTSS
- Director, UM
- Senior Program Manager
- Manager, Vendor Management
- Manager, Clinical Services Quality and Compliance
- Strategy Program Manager, Quality
- Senior Decision Support Analyst, Quality
- Lead Risk and Compliance Case Manager

The following areas were reviewed by the QM/Quality Improvement (QI) review team to determine [redacted]'s compliance with federal regulation, contract expectations, and MCO P&Ps.

- QM/QI unit and committee structure
- QM/QI program description and evaluation
- Member and provider satisfaction surveys
- Maintenance of medical records
- Critical incident (CI) reporting and remediation

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- Provider practice analysis
- PIPs (detailed discussion in Section 13)
- PM (detailed discussion in Section 14)

Overall Assessment

The QM/QI department of [redacted] has faced significant challenges throughout the past several years. In 2017, the department did not evidence the anticipated maturation of the department expected since the MCO started operations in 2014. At the time of the 2018 EQR, positions were added to support expanded management of the QM/QI unit and program and to provide greater coordination of QM/QI activities. Early in 2019, it was determined that the department leadership and supporting staff were not meeting the need for improvement in the QM/QI department; an Acting Director of Quality stepped in to assess existing team members, QM/QI initiatives, and overall approach to QM and improvement throughout [redacted]. Early in 2020, [redacted] hired a Quality Director, fulfilling the contractual requirements for this position. Throughout 2020, the Quality Director assessed the QM/QI department staff and operations, assessed the need for additional staff, and approaches to quality initiatives; open positions were filled and new positions were added to the department. Additional positions of note are: the Strategy Program Manager position that is focused on the PCP profile, True Performance, Emergency Medical Record (EMR) Resident Assessment Protocol, Provider Liaison, and the four additional QM Analyst positions to support quality initiatives — particularly PIPs. The Strategy Program Manager position has been instrumental in gaining access to EMRs for improvement in collecting information to improve Healthcare Effectiveness Data and Information Set (HEDIS®) rates. The QM Analyst positions are tasked with driving improvement in the PIPs and working closely with the performance measurement team to ensure correct application of PIP measure specifications and to assess the effectiveness of interventions. With the additional staff and the current direction of the QM/QI department described below, the EQRO is cautiously optimistic about the direction in which the department is headed. Innovation and successful implementation and management of initiatives will be key to achieving the results the MCO anticipates.

The 2020 Quality Program Description contains appropriate goals and objectives and annual work plan; it also integrates information about the quality initiatives in place by subcontracted/delegated entities who serve the [redacted] membership. The document describes the committee structure and the roles and responsibilities of the various subcommittees that report to the [redacted] QI/UM Committee. The Committee serves as the primary oversight body for those day-to-day functions as detailed in the QI and UM Program requirements of the State Managed Care Contract, [redacted] Health and Social Services, and [redacted]. The Committee Bylaws detail the QI/UM committee and internal QI subcommittee accountability structure, the purpose of the committees, the membership, and the function of committee meetings. The roster of committee members identified in the meeting agenda was lengthy; however, there was a significant number of members identified who did not attend any

of the meetings in 2020. The roster of members should be reviewed to ensure that it is accurate and members should be held accountable for regular meeting attendance and participation.

One of the achievements identified by [redacted] for 2020 was monitoring and ameliorating health disparities through a systematic approach utilizing data to identify health disparities. The goals of the program are to ensure the delivery of culturally and linguistically appropriate services for the diverse [redacted] membership, focus on identified QI intervention opportunities that reduce health care disparities, and improve access to care. These efforts to leverage data to identify health disparities and implement interventions to reduce disparities are steps in the right direction, but the challenges of accurate and complete race, language, and ethnicity data persist, and the effectiveness of the efforts has not been fully assessed.

The annual evaluation of the QI/UM Program includes a description of the QI and UM activities and initiatives throughout 2019. The analysis included evaluation of service indicators, consumer and provider satisfaction, evaluation of clinical care, evaluation of the LTSS program, audit activities, and recommendations for 2020. The annual evaluation included a number of data analyses, particularly related to HEDIS measures and quality PMs for value-based purchasing, with conclusions and recommendations for improvement noted.

The MCO conducted the Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS), Child CAHPS, Adult Experience of Care and Health Outcomes (ECHO), Child ECHO, and a CM satisfaction survey to assess member satisfaction with the MCO and health care services. In response to the pandemic, NCQA released guidance about the HEDIS CAHPS program in March 2020. While NCQA did not extend the data submission deadline of May 2020, they did allow for modifications to the protocol. In April 2020, NCQA released additional guidance regarding scoring for Health Plan Ratings. While NCQA required submission of HEDIS and CAHPS data for commercial and Medicaid plans, they are not scoring plans using Health Plan Ratings in 2020. The top three adult CAHPS results for [redacted] were Rating of Specialist, Getting Care Quickly, and Getting Needed Care. The bottom three results in need of improvement were Coordination of Care, Customer Service, and Rating of Personal Doctor. Overall, as compared to the scores in 2019, the 2020 Child CAHPS survey scores were high/improved in most areas with some opportunities for improvement in Getting Needed Care and Getting Care Quickly. Survey results are made available to members via newsletters. Overall, the 2020 Adult ECHO survey results were satisfactory. [redacted]'s BH team provided information about different kinds of counseling/treatment and educating members about online support groups like Digital All Recovery and online Alcoholics Anonymous. To address the lowest scoring questions in the ECHO, [redacted] added staff training about the different treatment options and different types of peer-run supports and sober supports in the community.

One area under the purview of the QI/UM Department that warrants attention is provider profiling; the MCO has not taken a robust approach to ongoing provider profiling. Provider practice analysis should be reviewed regularly to assess a provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the provider related to medical

treatment. The MCO Peer Review Committee (PRC), which should be responsible for this regular assessment, has not consistently met to review patterns and trends within a provider group or for an individual provider.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
Departmental leads demonstrate active roles within PIPs and other QI initiatives.	Substantially Met	There has been significant improvement through the first half of 2021 in integration of quality throughout all areas of the organization as evidenced by participation and departmental involvement in the PIPs and other quality initiatives presented in PowerPoint and onsite discussion. However, throughout 2020, the appropriate level of integration was just beginning and integration of quality throughout the organization was not evident through improvement in quality measurement and initiatives.	Maintain and document robust integration and active roles of departmental leads within PIPs and other QI initiatives.
The MCO and its delegates have a training program that covers fundamental QM concepts and QI methodologies. (3.20.3.1)	Partially Met	The QI department did not provide any training to delegates/subcontractors in 2020. However, as of May 2021, a full training program for QI department staff, as well as QI delegates/subcontractors, has been implemented. Applicable delegates/subcontractors will complete training by June 30, 2021.	Complete training of QI delegates/subcontractors. Provide documentation of training completion.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has defined roles, functions, and responsibilities of the QM/QI committee that specify the following: • The committee has oversight responsibility and input on all QM/QI activities. • The committee is accountable to the MCO's executive management. • Membership includes a representative from the provider community and the member community. • At a minimum, regularly scheduled quarterly meetings. • Maintenance of appropriate documentation of committee meetings, activities, findings, recommendations, and actions. • Departmental leads actively participate in the [redacted] Quality committee. (3.13.1.4.2)	Substantially Met	There has been improved participation in the QI/UM committee by department leads through 2021, but participation was lacking for most of 2020. The committee meeting notes indicate a significant number of committee members, many of whom have not participated in the meetings in over one year. The MCO should monitor required meeting attendance and participation and/or update the list of committee members to maintain relevance.	Establish meeting attendance and participation requirements for QI/UM committee members. Update QI/UM committee member roster to relevant members.
The MCO participates in efforts to prevent, detect, and remediate CIs. (42 CFR 438.330 (b) and 3.13.3.5)	Partially Met	Throughout 2020, the MCO was in the process of developing interventions and enhancements to efforts to prevent, detect, and remediate CIs. The end-to-end process was owned by the Quality department beginning in 2021.	Provide evidence of implementation of interventions and enhancements to prevent, detect, and remediate CIs.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO participates in efforts to improve health disparities identified through data collection. (3.13.3.6)	Substantially Met	The MCO has established a Health Equity Committee (HEC) and utilizes dashboards to monitor health disparities. There is no member representation on the HEC, which, while not contractually required, could provide good insight into health equity challenges faced by members. The MCO relies on race, ethnicity, and language data from the State for data analysis; this data may lack validity and reliability, which could call into question some of the health disparity dashboard results. The MCO is working to enhance the race, ethnicity, and language data through electronic medical records, but has not yet begun to integrate this data.	Identify and implement ways to improve the validity and reliability of the health disparity analysis based on race, ethnicity, and language data. Continue development of efforts to improve health disparities.
The MCO has a process in place to regularly evaluate services provided to members and identify areas for improvement. This process includes analysis of: • Over- and under-utilization of services. • Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. • Member satisfaction. • Provider satisfaction. • CIs. • Grievances and appeals. (42 CFR 438.330 (b) and 3.13.3)	Partially Met	The quality program evaluation included tracking/trending analysis of CI, but the policy for quarterly and annual evaluation does not include CIs.	Update policy QI-027-DE Evaluation of Quality Improvement and Utilization Management Activities to include tracking/trending and analysis of CIs.
The MCO P&Ps ensures that medical records are preserved and maintained for a minimum of seven years after contract. (3.13.12.10)	Not Met	A policy that ensures medical records are preserved and maintained for a minimum of seven years after contract was not submitted.	Develop or submit an existing policy that ensures medical records are preserved and maintained for a minimum of seven years after contract.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has a CI management system that includes reporting, documenting, and investigating CIs in compliance with State law and policy. (3.13.9.1)	Partially Met	All CIs are reported to [redacted] via Move It within one business day of the reporting of the incident. The CI will be investigated by CC within 30 days, and this follow-up will be uploaded to Move It as a final report within 30 business days of initial reporting. The CI reporting is audited for completeness in the Medical Information Management System. The CIs are audited for type of incident, agencies notified of incidents, and the reporters of the CIs. The MCO has a workflow that details this process, however the workflow indicates that the starting point for a CI is within CC/CM and this is not the only point where a CI can be identified and where the process begins.	Update and refine the workflow for management of CIs to indicate identification of a CI may occur by anyone, not exclusively a care coordinator/case manager.
The MCO provider practice analysis includes review of a provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all grievances filed against the provider related to medical treatment. (3.13.7.1.1)	Partially Met	The MCO generates reports that are submitted to the State that are based on provider practice analysis. However, there is not a standing meeting or review of these reports by the PRC to assess the quality of care by providers.	Develop and document a process for regular review of the provider practice analysis results by the PRC.
The MCO provider practice analysis includes implementation of a CAP, if necessary. (3.13.7.1.3)	Partially Met	The MCO provided a description of the provider CAP process based on formal peer review. However, there may be instances, based on provider practice analysis (not rising to the level of formal peer review), that result in the need for a CAP. This process is not documented and was not described as a standard process.	Develop and document a provider CAP process based on results of provider practice analysis.

2021 External Quality Review [redacted]

[redacted]

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO provider practice analysis includes development of policy recommendations to maintain or enhance the quality of care provided to members. (3.13.7.1.4)	Partially Met	The MCO states that the goal of provider practice analysis is to evaluate the quality of care and services rendered in order to identify opportunities where [redacted] and the provider can work together to improve the health care of our members. However, this process to review the provider practice analysis and develop policy recommendations based on the results is not documented and was not described as a standard process.	Develop and document a process for policy recommendations to maintain or enhance the quality of care provided to members based on provider practices analysis.
The MCO provider practice analysis includes a review of the appropriateness of diagnosis and subsequent treatment, maintenance of provider medical/case records, and adherence to generally accepted standards in terms of outcome and care. (3.13.7.1.5)	Partially Met	The MCO states that the goal of provider practice analysis is to evaluate the quality of care and services rendered in order to identify opportunities where [redacted] and the provider can work together to improve the health care of our members. However, this process is not documented and was not described as a standard process.	Develop and document a process for regular review of the provider practice analysis results by the PRC.
The MCO peer review process includes receipt and review of all written and oral allegations of inappropriate or aberrant service by a provider. (3.13.7.1.7)	Partially Met	The peer review process described includes receipt and review of all written and oral allegations of inappropriate or aberrant service by a provider. The supporting documentation (peer review form) was not submitted.	Submit the Quality of Care/Quality of Service Peer Review Form.

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Availability of Services — Cultural Considerations, Delivery Network, Provider Selection, and Timely Access

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 OON.

To evaluate [redacted]'s compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of [redacted]'s RFI response, consisting of policies, procedures, and supporting documentation. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite meetings held August 10, 2021–August 12, 2021. Interviews were conducted with a variety of staff including but not limited to:

- SVP, Medicaid Markets
- VP, Operations, COO
- Director, Provider Experience
- Director, Provider Contracting
- Director, Payment Integrity
- Director, Provider Information Management
- Associate Project Manager, Provider Network
- Manager, Customer Service
- Manager, Operations Controls and Compliance
- Manager, Data Analytics
- Manager, Provider Relations
- Senior Project Manager, Provider Network
- Project Manager, Provider Network

Overall Assessment

In [redacted], by contract, [redacted] is required to develop and maintain a PNDMP. The PNDMP acts as the Network Management program description outlining the different populations served, goals, objectives, outcomes and action steps taken to develop, and monitor and maintain [redacted]'s network of providers. While the expectation is that [redacted] use the PNDMP as a living document, updating it as the year unfolds, annually the State requires an evaluation of the effectiveness of the PNDMP; the results to be used as the basis for the next year's plan. [redacted] has embraced the concept of the PNDMP and demonstrates a CQI mindset in the enhancements and evolution of this document. [redacted] monitors its network adequacy monthly via cross-departmental meeting using its robust reporting capabilities to assess geo-spatial analytics, grievance, and CI data, as well as member and provider experience information to evaluate the effectiveness of its PNDMP. Account Executives (AEs) are assigned to providers and are available to conduct office visits or virtual visits during the PHE; a total of 465 visits were conducted in 2020. AEs play a critical role in communicating [redacted] policy, conducting training on new business processes, and providing technical assistance to

their assigned provider community. Visits follow a predefined agenda to ensure consistency of information. Various provider forums are conducted at different locations and times throughout the year. The year 2020 saw these face-to-face meetings move to a virtual environment with a total of four different forums held in June 2020 and November 2020. Annual provider satisfaction and member experience surveys are conducted and results are used to inform network management and oversight activities.

Delegation of network development and management activities occurs nationally with [redacted] and [redacted] and locally with Christiana Care Health System ([redacted]) and [redacted] as credentialing delegates. More information on Delegation Oversight can be found in the Sub-Contractual Relationships and Delegation section of this report. [redacted]'s network management team has partnered with delegates to ensure a clear understanding of [redacted] contract requirements, and participates in ongoing monitoring and oversight to ensure compliance with key indicators and service level agreements. [redacted] has also contracted with recognized Medicaid Accountable Care Organizations (ACOs) and is actively engaged in the development and proliferation of alternative payment models and value-based contract relationships. [redacted]'s alternative payment program is geared towards primary care and incorporates the [redacted] quality PMs and other quality indicators.

[redacted] maintains a large network of providers and offers a Wellness Registry, powered by Aunt Bertha™ that lists community-based support and service organizations; access is made available to providers via the [redacted] Community Resources page. An overview of the [redacted] network is as follows:

Provider Type	Number of Providers
PCP	1212
Specialty Care Provider (SCP)	5816
BH	1144
Hospital	12
Urgent Care	10
Nursing Facility (NF)	42
Dental	21
Vision	54
Assisted Living Facility	13

Provider Type	Number of Providers
Home Modifications	11
Home Delivered Meals	7
Home Health	19
Adult Day Services	9
Respite Care	33
Personal Assistance Service Agencies	49
Personal Emergency Response System	13
Consumer Directed Fiscal Intermediaries	2

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[redacted] operates a provider website and contracts with NaviNet for its online provider portal. The NaviNet portal allows for claims status check, eligibility verification and PA submission and response, as well as provider appeals and claims disputes/complaint submission. [redacted] also posts provider reports and provides secure messaging features through its portal. The provider contract templates meet all contract requirements. Submitted P&Ps demonstrate compliance with providing women with direct access to a women's health practitioner in addition to their PCP of record, allow for a second opinion, and demonstrate the use of single case agreements and OON authorizations to ensure members receive medically necessary care when such care or specialty is not available in-network.

Providers have access to training and education materials through the NaviNet portal and receive new provider orientation when entering the network. Provider forums were hosted in June 2020 and November 2020, newsletters and provider bulletins are disseminated as necessary. The Provider Manual is a critical resource document for providers and their office staff; it is made available electronically. [redacted]'s Provider Manual includes specificity around appointment availability standards but does not incorporate the managed long-term services and supports (MLTSS) alternative service wait time standards nor does it capture missed or late visit reporting requirements for certain MLTSS provider types as required by contract.

[redacted] maintains a provider directory, which contains all contractually required elements. [redacted] has created separate directories for different provider types including one specific to home- and community-based service (HCBS) providers. On a quarterly basis [redacted] relies on its vendor, Atlas Systems to conduct verification (fax and telephonic) on a statistically valid sample of the provider types contained within the directory. Verification of provider data can occur through many different mechanisms but pertinent information such languages spoken, wheelchair accessibility, and open panel status is captured and evaluated, along with address, phone, specialty, etc. It is unclear how [redacted] assesses accommodation for individuals with physical or mental disabilities, nor was there indication that [redacted] was gathering data on completion of cultural competence training. Secret shopper calls were conducted on the LTSS directory and found a host of errors including:

- LTSS Directory, Page 1 — [redacted]
  - [redacted].
  - [redacted] does not appear to be open; the number ([redacted] is not working.
- LTSS Directory, Page 3 — [redacted]

- [redacted] is listed but does not provide attendant care.
- [redacted] is also listed under attendant care — the listed number goes to a completely different provider name and location.

- LTSS Directory, Page 4 — [redacted]
  - [redacted] was contacted but does not provide home delivered meals.

In review of the submitted procedure CRD-001A Confidentiality of Provider Information, Non-Discriminatory Selection, and Directory Accuracy it was noted to lack the necessary [redacted] specific requirements related to quarterly review of a statistically valid sample of providers, across all provider types included in the Provider Directory. Given the results of the secret shopper calls noted above, [redacted] must address the issues with the validity of information as it pertains to the LTSS Directory and update its P&Ps to reflect its methodology to select a statistically valid sample of all provider types within the directory.

Network monitoring activities are outlined in the PNDMP and include geo-spatial analysis of the time/distance, open/closed panels, and provider ratio requirements outlined in the contract. Appointment availability monitoring is conducted quarterly and is a shared responsibility between the Medicaid MCOs. Network changes (additions and terminations) are monitored monthly. Grievance and CI information is reviewed and, when necessary, providers are brought to the PRC for further evaluation and continued participation in the network. Provider satisfaction is monitored through annual surveys and through review of trends related to provider complaints. There was evidence of linkages to Program Integrity, Quality, and other health plan operation areas as a routine part of day-to-day network management. Evidence of network opportunities by specialty and geography were identified by [redacted], and plans and progress to remediate the gaps were outlined in the PNDMP and discussed during the interviews. One area of opportunity for [redacted] is related to the incorporation of additional information into the PNDMP to more fully evaluate network adequacy and capacity. [redacted] should incorporate LTSS provider monitoring and oversight activities such as missed and late visit reports and alternative service wait times.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO's PNDMP includes the following components: • Summary of participating providers, by type and geographic location in the State. • Demonstration of monitoring activities to ensure that access standards are met and that members have timely access to services. • A summary of participating provider capacity issues by service and county, the contractor's remediation and QM/QI activities, and the targeted and actual completion dates for those activities. • Network deficiencies by service and by county, and interventions to address the deficiencies. • Ongoing activities for provider network development and expansion, taking into consideration identified participating provider capacity, network deficiencies, service delivery issues, and future needs. (42 CFR 438.207 and 3.9.2.1)	Substantially Met	[redacted] has embraced the PNDMP, resulting in a robust, one-stop overview and analysis (in the case of the PNDMP Evaluation) of the [redacted] provider network. It was noted that the plan may be enhanced by adding in the LTSS Alternative Service Wait Times (LTSS appointment standards found at 3.9.14.4) and the Missed and Late Visit report data as mechanisms for ensuring adequate capacity to serve the DSHP Plus LTSS population. Additionally, it was noted that the 2020 PNDMP Evaluation was submitted in ***draft*** form. Since the evaluation helps to drive the next year's activities, it is helpful to have the evaluation completed within the first quarter of the new year.	Update the PNDMP to incorporate the LTSS Alternative Service Wait Times and Missed and Late Visit report data. Finalize the 2020 PNDMP Evaluation.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has adequate methods to verify compliance with state-determined network adequacy standards and produces quarterly geo-spatial analysis reports. Methods to detect network adequacy should include at a minimum geo-spatial reports, tracking PCP open/closed panels, appointment availability within defined State standards, and assessment of LTSS gaps in care. (3.9.2.3)	Substantially Met	[redacted] has embraced the PNDMP, resulting in a robust, one-stop, overview and analysis (in the case of the PNDMP Evaluation) of the [redacted] provider network. It was noted that the plan may be enhanced by adding in the LTSS Alternative Service Wait Times (LTSS appointment standards found at 3.9.14.4) and the Missed and Late Visit report data as mechanisms for ensuring adequate capacity to serve the DSHP Plus LTSS population.	Update the PNDMP to incorporate the LTSS Alternative Service Wait Times and Missed and Late Visit report data.

Regulation/Contract Standard Not Fully Compliant	2021 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 the State's access standards that includes the following: • Considers State standards for timely access, consistent with the needs of the member. • Ensures network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees. • Makes services in the contract available 24 hours a day, seven days a week, when medically necessary. • Established mechanism to ensure compliance by providers. • Regular process to monitor compliance. • Process to take corrective action when providers fail to comply. (42 CFR 438.206(c)(1) and 3.9.1.2.5)	Partially Met	[redacted] has demonstrated application of CQI principles in monitoring data pertinent to network adequacy and capacity in order to assure adequate capacity of its provider network; much of its network monitoring program and results are included in the PNDMP, Annual PNDMP Evaluation, and the Network Development Strategic Plan. However, there were no overarching [redacted] specific P&Ps that address how [redacted] approaches overall recruitment, retention, and termination activities to support ongoing network management.	Develop and implement formal P&Ps that reflect [redacted] specificity in how [redacted] monitors its network for changes that may impact its ability to successfully assure adequate access, availability, and capacity to provider services under its contract with [redacted].

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has P&Ps in place for maintaining an appropriate network of providers taking into consideration membership, utilization, number and type of providers, providers with closed panels, and geographic location. (42 CFR 438.206 and 3.9.1.2.4)	Substantially Met	[redacted] has demonstrated application of CQI principles in monitoring data pertinent to network adequacy and capacity in order to assure adequate capacity of its provider network; much of its network monitoring program and results are included in the PNDMP, Annual PNDMP Evaluation, and the Network Development Strategic Plan. However, there were no overarching [redacted] specific P&Ps that address how [redacted] approaches overall recruitment, retention, and termination activities to support ongoing network management.	Develop and implement formal P&Ps that reflect [redacted] [redacted] specificity in how [redacted] monitors its network for changes that may impact its ability to successfully assure adequate access, availability, and capacity to provider services under its contract with [redacted].
The MCO's provider recruitment P&Ps describe effective responses to a change in the network that affects access and the MCO's ability to deliver services in a timely manner. (3.9.1.2.5)	Partially Met	[redacted] has demonstrated application of CQI principles in monitoring data pertinent to network adequacy and capacity in order to assure adequate capacity of its provider network; much of its network monitoring program and results are included in the PNDMP, Annual PNDMP Evaluation, and the Network Development Strategic Plan. However, there were no overarching [redacted] specific P&Ps that address how [redacted] approaches overall recruitment, retention, and termination activities to support ongoing network management.	Develop and implement formal P&Ps that reflect [redacted] [redacted] specificity in how [redacted] monitors its network for changes that may impact its ability to successfully assure adequate access, availability, and capacity to provider services under its contract with [redacted].

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has P&Ps describing how the Provider Directory is updated, frequency of updates (Quarterly), and validation of information in its Provider Directory, including the data elements listed in Section 3.14.1.6.1 (e.g., open/closed panel, languages, Americans with Disabilities Act [ADA] compliance, etc.). (3.14.1.6.6)	Substantially Met	Submitted procedure CRD-001A Confidentiality of Provider Information, Non-Discriminatory Selection, and Directory Accuracy lacks the necessary [redacted] specific requirements related to quarterly review of a statistically valid sample of providers, across all provider types included in the Provider Directory. Secret shopper calls found the LTSS directory to contain multiple issues such as provider telephone and address mismatches and listing providers under services they do not provide.	Update the CRD-001A procedure or create a separate P&P governing the [redacted] Provider Directory requirements addressing the following: the methodology used to draw a statistically valid sample; the frequency of updates (Quarterly), and; incorporating and reporting on all the provider types found in the Provider Directory (e.g., open/closed panel, languages, ADA compliance, etc.). Implement action steps to correct the process by which the Provider Directory accuracy is assessed based on identified findings.
The Provider Manual contains all 35 elements required by the contract. (3.9.6.3.5)	Substantially Met	The Provider Manual includes specificity around appointment availability standards but does not incorporate the MLTSS appointment availability standards (3.9.6.3.5.5). Additionally, it does not capture missed or late visit reporting requirements for certain MLTSS provider types (3.9.6.3.5.31).	Update the Provider Manual to include the MLTSS appointment standards and requirements for reporting missed and late visits to ensure compliance with contractual requirements.

Provider Selection and the Credentialing File Review Process

Credentialing support is provided by [redacted]s and is conducted in accordance with NCQA standards and modified as necessary for [redacted] specific requirements. [redacted]s is responsible for coordinating the national credentials committee while the [redacted] CMO is responsible for chairing the PRC. Findings and recommendations from the PRC are communicated to the national credentialing committee. [redacted] maintains written P&Ps outlining its provider selection activities, which comport with federal and, at times, State specific requirements. [redacted]'s internal guidance documents for provider selection include non-discrimination language and providers are also

required to practice non-discrimination in their approach to patient selection and treatment planning. However, while the documents submitted meet general credentialing and recredentialing requirements they often miss [redacted] specificity. For example CRP-004 Ongoing Monitoring, Interventions and Reporting Policy, lacks specificity related to checking the Social Security Death Master File (SSA DMF) which should be monitored monthly. The MSA requires written P&Ps that demonstrate compliance with [redacted]'s provider selection requirements — many of the submitted documents lack specificity. Recredentialing follows a three-year cycle except for LTSS provider types, which are recredentialed annually. Peer review activities are operated at the local level by the CMO or designee and follow all confidentiality protections, including a code of conduct for non-employee committee participants.

Delegated Provider Network Development: Credentialing

[redacted] currently delegates credentialing and recredentialing of practitioners, in the local market, to [redacted] and [redacted]. Delegation oversight of these credentialing entities includes review of standards and review of (re)credentialing files. In 2020, [redacted] was under CAP, focused on ensuring more rapid exchange of delegate rosters that will allow [redacted] to maintain its compliance with the State's requirement to turnaround a complete credentialing application and load the provider into the billing system in 45 days. Both [redacted] and [redacted] were approved for continued delegation and as of the time of the review all CAPs had been closed.

[redacted]'s newly created [redacted] works with [redacted], Quality, and Compliance units to ensure oversight of delegated credentialing to national partners [redacted] and [redacted]. The 2020 annual oversight audits were completed and each vendor was recommended for continued delegation.

The credentialing file review was performed using the File Review Protocol methodology outlined in Section 3. File review encompassed initial credentialing activities for organizational providers and independent practitioners. A sample of 30 credentialing files (15 initial and 15 recredential) were selected, including LTSS provider types. The files were assessed for compliance with Balanced Budget Act (BBA) regulations, State contract requirements, and [redacted] internal policy standards. The following elements were included in the review:

- Credentialing entity
- Verification of medical licensure, board certification, Drug Enforcement Administration licensure (if applicable), and malpractice insurance coverage

- Documentation of National Practitioner Data Bank and/or Office of Inspector General queries:
  - List of Excluded Individuals and Entities, System of Award Management, Excluded Parties List System, and SSA DMF
- Signed and dated provider attestation
- Date of previous credentialing for recredentialing, if applicable
- Logs of attempts to reach providers for credentialing, if applicable
- Documentation of internal quality review, if applicable (excludes peer review documentation)
- Documentation of decision and decision date

Overall, the practitioner and institutional files reviewed demonstrated compliance with [redacted]'s required 45-day turnaround time for all initial applications. Recredentialing activities occurred within the one-year cycle for LTSS providers and three-years for all other practitioners and institutions. Evidence of sanction and debarment checks, SSA DMF review, collection of Clinical Laboratory Improvement Amendments waivers, and provider disclosure forms were all evidenced in the file review or supported by P&P. Interview sessions dedicated to file review demonstrated consistency with [redacted]'s submitted written response. The files reviewed were found to have greater than 90% compliance in the required elements.

Provider Terminations and the Provider Termination File Review Process

When a provider is terminated from an MCO network, members who had an established relationship or who had an ongoing plan of care can experience disruption in access and availability. To decrease the impact to members, MCOs alert members to the impending provider termination and provide assistance to transfer medical records and/or locate a new provider. [redacted]'s provider termination P&Ps reflect the appropriate lookback periods to determine established relationships and consider any open service authorizations to limit disruption to members. Letters are sent to members and members are encouraged to call Member Services should they need assistance with locating a

new provider. [redacted] updates the system that feeds the Provider Directory to ensure that all known network changes are processed within the required 30-day window.

Davis is [redacted]'s national vendor for vision benefit services and is used in the [redacted] market by [redacted] to provide vision benefits to its membership. Davis is responsible for developing [redacted]'s optometry and vision service provider network. As part of its network management functions Davis is required to operate a provider call center, subject to the call center requirements outlined in [redacted]'s MSA with the State, as well as implementing a provider complaint system and processing provider terminations from the network to ensure [redacted] receives timely notification of network changes. Delegate oversight information demonstrates that [redacted] has been working with Davis to address identified compliance issues.

A provider termination file review was not performed due to [redacted]'s extended implementation timeframe of its prior provider termination CAP, which remains under development as of this report. The EQRO encourages [redacted] to fully implement its CAP and to develop an overarching, end-to-end policy that addresses provider terminations, inclusive of the role that delegate provider roster exchanges play in the process, addressing the role and responsibility of each entity and business unit and the process used to ensure ongoing compliance and quality assurance.

Regulation/Contract Standard Not Fully Compliant	2021 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. (3.9.1.2.5)	Partially Met	Policy PC 606 MD DE Development of Provider Network does not address all considerations when building a network as required in section 3.9.1.2.4. The Network Recruitment and Retention plan is a good overview document but does not satisfy the contractual requirement of developing a P&P. The Provider Termination workflow, while detailed, requires an overarching P&P that governs the provider termination approach and from which all other policies (e.g., PCP, SCP/Hospital Termination Member Notification policies) flow.	Update policy Development of Provider Network to reflect all considerations required by the MSA in development of the provider network. Develop and finalize an overarching Network Recruitment and Retention policy. Develop and finalize an overarching Provider Termination P&P.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO's credentialing and recredentialing P&Ps comply with 42 CFR 438.214 including: • Having written P&Ps • Follow State guidelines for (re)credentialing — every three years for non-HCBS providers and annually for HCBS • Non-discrimination, consistent with (42 CFR 438.12) • Does not employ or contract with providers precluded from participation (MCO must have a process to check its own internal providers). (3.9.7.1 and 42 CFR 438.12) As well as comply with NCQA standards for the credentialing and recredentialing of providers. (3.9.7.3)	Substantially Met	The documents submitted meet general credentialing and recredentialing requirements but often miss [redacted] specificity. For example CRP-004 Ongoing Monitoring, Interventions and Reporting Policy, Section III: Policy Statement indicates that the ensuing list is an "example" of the type of monitoring. [redacted] specifically requires that the SSA DMF be monitored monthly. This specificity is lacking even though the MSA requires written P&Ps.	Update existing P&Ps with the specificity required in the MSA for network development and management, including credentialing, recredentialing, ongoing monitoring, and interventions and reporting that may occur internally as well as, that required by the MSA.
The MCO's P&Ps include that the MCO provides written notice to members no less than 30 calendar days prior to the effective date of the termination of a PCP and no more than 15 calendar days after receipt or issuance of the termination notice. (3.9.18.2.1.1)	Substantially Met	[redacted]-ERB-POL 217 and [redacted]-ERB-POL 286 that cover PCP and SCP/hospital termination respectively meet requirements of the standard to provide written notice to members no less than 30 calendar days prior to the effective date of the termination of a PCP and no more than 15 calendar days after receipt or issuance of the termination notice. However, it was noted that the definition of PCP contained in [redacted]-ERB POL 217 is not consistent with the MSA definition of PCP.	Update P&Ps for member notification of a PCP termination to reflect the correct contractual definition of PCP.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO's P&Ps include that the MCO provides written notice to members no less than 30 calendar days prior to the effective date of the termination of a non-PCP provider (including but not limited to LTSS provider) and no more than 15 calendar days after receipt or issuance of the termination notice. (3.9.18.2.2.1, 3.9.18.2.3.1)	Substantially Met	Submitted policies support the timeframes to provide written notice to members no less than 30 calendar days prior to the effective date of the termination of a non-PCP provider and no more than 15 calendar days after receipt or issuance of the termination notice identified in the standard. However, the RFI written response and the [redacted]-ERB-POL 286 regarding SCP/hospital terminations are not consistent when discussing the lookback period for claims. The written response indicates 12-months and the policy indicates six-months.	Update P&Ps for member notification of a PCP termination to reflect the lookback period for open authorizations and claims; ensure written documentation (e.g. desk level procedures, training decks, etc.) consistently reflects the lookback period.
The MCO's P&Ps include that hospital terminations are reported to the State no less than 30 calendar days prior to the effective date and within five business days of receipt of the termination for providers. (3.9.18.3.1.1, 3.9.18.3.2.1)	Substantially Met	Policy [redacted]-ERB-POL 286 SCP and Hospital Terminations P&P was received. This P&P does not address the requirement to notify [redacted] no less than 30-calendar days prior to the effective date and within five-business days of receipt of the termination for providers.	Update P&Ps for notification of hospital and provider terminations to evidence compliance with the [redacted] notification timeframes for hospital and provider terminations.

Clinical Practice Guidelines and Coverage, and Authorization of Services

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.

To evaluate [redacted]'s compliance with UM standards and requirements, Mercer reviewed information submitted by [redacted] through the RFI and the virtual onsite review that took place on August 10, 2021–August 12, 2021. The virtual onsite review evaluating UM requirements included key leadership from the MCO, including but not limited to:

- CMO
- SVP, Medicaid Markets
- VP, [redacted] Markets, CEO
- VP, Medicaid Business Solutions
- VP, Care Management
- Director, UM

- Director, LTSS
- Manager, UM
- Manager, CCC
- Manager, Data Analytics
- Supervisor, Clinical QM EPSDT
- Senior Project Manager
- Client Relations managers
- Risk and Compliance Case Managers

Areas reviewed included UM staffing and training, UM delegation, UM operations, UM decision-making process, and adherence to UM standards and program requirements.

Overall Assessment

The structure and the vision of the UM department is described within the UM program description and reviewed comprehensively through the annual program evaluation. Ongoing oversight is provided through participation within the QI/UM committee. Tracking and trending of data is reviewed to evaluate the processes in place. The UM department oversight is led by the CMO, along with the VP of Care Management. Additional organizational structure includes the Director of UM with teams that report through a Manager of UM CC. Each UM team has a supervisor, licensed UM reviewers, and UM Support associates. All UM staff are 100% dedicated to [redacted] business. The Director of UM also oversees the delegated relationships with [redacted], and [redacted]. It is not clear, however, the oversight plan or the process that is followed when a vision service requested is not granted. [redacted]'s 2021 staffing plan was approved by [redacted] in March 2021. [redacted] has made progress in the efforts to integrate UM with other internal departments including CC and CM.

UM decision-making and timeliness are well defined through P&Ps. UM processes, decisions, and notifications are made in accordance with applicable federal and State requirements, [redacted] contract, and accrediting bodies such as NQCA. Covered services that require PA are transparent to both providers and members and there are no services that require a PCP referral. UM continues to follow the COVID-19 authorization guidelines implemented in March 2020/April 2020 with some authorization requirements waived or extended. [redacted] developed training and guidance to improve discharge planning but audits revealed three areas that did not meet the 85% threshold.

[redacted] submitted a robust training plan along with a plan to utilize Interqual as a certified trainer. Staff completed a baseline inter-rater reliability (IRR) assessment through training resources from the Interqual Learning Library in the Change Healthcare platform. BH UM reviewers also attended training sessions on the American Society of Addiction Medicine criteria.

[redacted] transitioned from [redacted] ([redacted]) to [redacted] in February 2021. Operational processes including reporting requirements, claims processes, and meeting cadence were aligned with [redacted]. [redacted] also developed a strong oversight plan that includes annual training, IRR, evidence of policies, meeting schedules, reporting, tracking and trending of data, and follow-up collaboration for members who have received a service denial.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has a process to evaluate a delegated entity's compliance with federal requirements set forth under 42 CFR 438.210, which includes: UM, program structure, coverage, authorization of service, notice of adverse benefit determination (standard authorization and expedited), and the compensation for utilization activities. (42 CFR 438.210)	Minimally Met	As a follow-up from the subcontractual/delegated relationships track team, [redacted] submitted a table that summarized the subcontractors for [redacted] and included the [redacted] business owners. This table included [redacted] as a subcontractor for UM. The RFI submission did not include [redacted] as a UM delegate and it was not clear during onsite discussion what role [redacted] had in UM.	Provide clarification on [redacted] delegation including the following: documentation of the delegated functions, the process that is followed if a request for services is not granted, and the oversight plan. Provide the oversight plan for the vision benefit.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has a formal approach to ensure a successful transition of care such that the P&P to identify, authorize, and ensure discharge planning needs are fully addressed identifies the roles and responsibilities of all individuals who may be taking part in the discharge planning process (i.e., PROMISE members, those with comprehensive needs or those at-risk for readmission.) (3.12.2.1.13)	Partially Met	[redacted] has developed guidance for staff, training and auditing to improve discharge planning and coordination. At the time of the review, auditing was in progress and there were three areas that are below an 85% threshold. The audit document does not include the internal benchmark.	Provide ongoing discharge planning audit results and detail of findings with follow-up intervention. Include benchmarking for the areas of audit.
The MCO has a process to coordinate benefits provided by the State, such as dental services for children, prescribed pediatric extended care, day habilitation, non-emergency transport, specialized services as identified through Preadmission Screening and Resident Review assessments, Pathways employment services, and BH services (children and adult). The process also provides a means for coordination of benefits with Medicare, and with other State payment guidelines. (3.4.1.2)	Substantially Met	[redacted] has a process in place to coordinate benefits with other payers. At the time of the review, the discharge auditing was in process; audit results will be reviewed to assess fidelity to the discharge planning and coordination process.	Provide audit results for discharge planning for members that have a combination of benefits.
The MCO has a process to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (42 CFR 438.206(c)(2))	Substantially Met	[redacted] trains on cultural sensitivity and CC/CM processes include cultural considerations. Currently, there is not a process to evaluate that cultural considerations are included through the UM process, which includes service authorizations for providers.	Include cultural considerations in UM auditing to ensure that members are receiving services matching needs as well as providers to meet those needs.

Enrollment and Disenrollment

The following federal regulations are addressed in this section: 438.56 (b–e) and 438.62.

The intent of these regulations is to ensure the MCO complies with the State enrollment and disenrollment requirements and limitations.

To evaluate [redacted]'s compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of [redacted]'s policies, procedures, workflows, and supporting documentation regarding member enrollment, re-enrollment processes, disenrollment processes, including member requests for disenrollment, and processes to support member transfers to another MCO within the State. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite meetings held August 10, 2021–August 12, 2021. The onsite meeting included key leadership from the MCO including but not limited to:

- SVP, Medicaid Markets
- VP, [redacted] Markets, CEO
- VP, Operations, COO
- VP, Medicaid Business Management
- VP, Medicaid Service Operations
- VP, Medicaid Business Solutions
- VP, Finance, CFO [redacted]
- Director, Provider Experience
- Director, Member Experience
- Director, Payment Integrity

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- Manager, Grievances and Appeals

Overall Assessment

[redacted] has a well-defined process to onboard new enrollees that includes new member welcome calls, new member welcome kits, completion of a Health Risk Assessment (HRA), and in-person new member orientation meetings (Zoom video conferencing during the PHE). New members coming into [redacted] are subject to a continuity period for any services and/or treatment plans that were in effect at the time of entry into managed care, regardless of whether the member transitioned from the fee-for-service system or another Medicaid MCO. [redacted]'s transition of care policies are consistent with regulatory requirements.

The State requires the use of the Member Transfer Continuity of Care Form to be used to exchange critical information between the sending and receiving MCO (for MCO-to-MCO transfers); this form is built into [redacted]'s member transfers between MCOs policy and supports ongoing service delivery during the transitional period. The required form includes information such as: open authorizations, current service providers, amount and duration of currently authorized services, recent emergency department (ED) or inpatient hospital stays, etc. When necessary the State or the sending MCO may exchange historical claim information with the receiving MCO to supplement information received on the State required form.

Per federal regulation, members are able to switch to another MCO without cause within the first 90-days of enrollment, during the open enrollment period, or re-enroll with the same MCO under automatic re-enrollment after a short period of ineligibility. For cause termination P&P's are consistent with regulatory requirements and apply to instances such as lack of provider specialty or service availability, loss of a network direct service or other long-term services providers that may impact a member's housing situation (for members receiving DSHP Plus benefits), or for moral and religious objections over the services the member seeks. While the MCO is afforded a right to request disenrollment of a member under certain circumstances and given the MCO's internal P&Ps evidence compliance with the federal requirements, [redacted] has not requested relief under this provision.

Should a member request disenrollment from the Medicaid program or request a transfer from [redacted] to another MCO, [redacted] directs those members to the State's Health Benefit Manager (HBM) for additional assistance. Through its submitted policies and in interviews with [redacted] leadership, [redacted] does not appear to engage the Member Advocate should identified concerns about [redacted] be raised by the member. [redacted] may benefit from assessing member reasons for transfer and, as appropriate, engaging the Member Advocate or other MCO staff to outreach and

offer assistance to members to address unresolved concerns; they could also assist members in moving through the transfer or disenrollment process such as having medical records transferred.

Mechanisms to identify and notify the State of members whose circumstances may support disenrollment from [redacted] and/or the Medicaid program are in place and are communicated to the State via the Weekly Issues spreadsheet; associated P&Ps are consistent with requirements. Reports submitted evidence compliance with requirements.

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.

Sub-Contractual Relationships and Delegation

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.

To evaluate [redacted]'s compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of [redacted]'s policies, procedures, workflows, and supporting documentation regarding subcontractual and delegated relationships. This review was conducted based on information submitted by [redacted] through the RFI and onsite meetings held on August 10, 2021–August 12, 2021. In addition to understanding [redacted]'s approach to delegation of oversight of external vendors and in consideration of the complexity of the relationships among the operating entities comprising [redacted], Mercer requested a presentation of specific information during the onsite meeting to better understand the interrelationships among the various internal operating partners as they relate to internal oversight and monitoring activities. The onsite meeting included key leadership from the MCO including but not limited to:

- SVP, Medicaid Markets

2021 External Quality Review

[redacted]

[redacted]

- VP, [redacted] Markets, CEO
- VP, Operations, COO
- VP, Medicaid Business Management
- VP, Medicaid Service Operations
- VP, Medicaid Business Solutions
- CMO
- VP, Care Management
- Manager, Operations Controls and Compliance
- Director, Provider Information Management
- Manager, Provider Information Management
- Director, Quality
- [redacted] Compliance Officer
- Lead Risk and Compliance Case Manager
- Lead Risk and Regulatory Intelligence Analyst

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Overall Assessment

Changes to [redacted]'s delegation oversight program were in process throughout out 2020 and continue into 2021. In part, these changes are a result of [redacted] transitioning responsibilities from [redacted] back into the local [redacted] plan and represent the creation of a Medicaid specific Vendor Management Oversight (VMO) team housed in [redacted]'s new [redacted]. Additionally, contracts previously held by [redacted] or other operating entities have been moved to [redacted] contracts with [redacted] addendums or onto [redacted] owned contracts. The following paragraphs provide a programmatic overview of [redacted]'s new VMO structure and approach. For the remainder of this section vendor and delegate are used synonymously.

Delegation oversight previously performed by [redacted] was transitioned back to [redacted] throughout 2020, with the exception of Pharmacy benefits, and [redacted] continues to build its VMO capabilities internally. [redacted]'s [redacted] provides support to [redacted] for oversight of its vendors (i.e., delegates) via its VMO team. Delegate oversight occurs in a matrixed fashion involving the VMO, Compliance, Quality, and FBOs (e.g., UM, credentialing, etc.). The VMO acts as the liaison with the delegate from an oversight perspective and works with the Compliance unit to ensure the VMO framework is compatible with the contract. FBOs are identified within each business unit and aligned with the delegate's scope of services. FBOs are responsible for the day-to-day operations and overall delegate relationship management including performing operational oversight, training, and audits. Results of delegate oversight activities are shared through the Quality committee structure (QI/UM Committee). All delegated activities follow NCQA standards and consist of a signed agreement documenting the delegated responsibilities and other pertinent contract elements, including any flow-downs from the MSA [redacted] has signed with [redacted]. [redacted] ensures that all delegates undergo a pre-delegation audit, ensures routine reporting and evaluation of performance vis-à-vis the vendor scorecard, and ensures an annual delegation audit occurs within the required timeframe. Delegation oversight audit tools have been developed to capture both NCQA and [redacted] specific requirements. Audit results are reported out at the NCQA and [redacted]-specific requirement levels and CAPs are requested when results fall below established thresholds. CAP oversight is shared between the [redacted] and VMO. [redacted] retains the final determination on decisions affecting delegated relationships.

After review and evaluation of [redacted]'s delegation oversight program the EQRO finds that [redacted] was compliant in how it conducted delegate oversight activities in 2020. The creation of the new VMO unit resulted in several process improvements including development of a delegate scorecard to track delegate compliance and performance, the implementation of the semi-annual delegate attestation process, establishment of the Vendor Oversight Governance Board, and rigorous oversight of [redacted] [redacted]'s implementation progress of its CAPs all demonstrate [redacted]'s commitment to building a strong and outcomes-oriented delegate oversight model. However, the RFI submission and in interviews with

[redacted] leadership, [redacted] was not able to consistently identify the services delegated to each vendor. These inconsistencies make it difficult to ensure VMO activities conducted comport with the actual delegation scope of work assigned to each vendor.

The following tables provides a high-level overview by delegated entity and the associated delegated responsibilities.

Entity	Responsibilities
Delegation Oversight Conducted by [redacted]	
[redacted]	Pharmacy Benefit Management, Provider Network Development and Management, Utilization/Benefit Management
Delegation Oversight Conducted by [redacted]	
[redacted]	Provider Information Management, Credentialing
[redacted]	Oversight of [redacted]
[redacted]	Provider Network Development and Management, Claims Payment, Utilization/Benefit Management
[redacted]	UM Decision Making
[redacted]	Nurse Advise Line
[redacted]	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee
[redacted]	Credentialing, Recredentialing, Primary Source Verification, Credentialing Committee

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Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has a clear P&P to evaluate a delegate, subcontractor or sister entities' compliance with State contract and federal requirements including pre-delegation, ongoing monitoring and oversight, and annual audits. The policy should indicate the ability to terminate delegated arrangements including requests from the State for termination. (5.1.2.1)	Substantially Met	[redacted] VMO policies outlining delegation oversight were submitted, but some documents were still marked draft. [redacted] could not consistently identify what services were delegated to a certain vendor.	Finalize all [redacted] VMO policies and desk level procedures. Submit a vendor roster outlining which services under its MSA with the State have been delegated to each vendor.

[redacted]

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Compliance with Federal Regulations for Medicaid Managed Care and State Standards — Grievance System

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 timeframes including requirements to adjudicate concerns under an expedited timeframe.

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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 grievances and appeals 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.

To evaluate [redacted]'s compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of [redacted]'s RFI response and supporting documentation including P&Ps, Member Handbook, [redacted]'s member website, grievance and appeal department structure, program highlights and updates since the 2020 review, and a selection of grievance and appeals case files. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite meetings held August 10, 2021–August 12, 2021. The virtual onsite meetings involved key leadership from the MCO including but not limited to:

- VP, [redacted] Markets, CEO Director
- VP, Operations, COO
- VP, Care Management
- Director, Provider Experience
- Director, Member Experience
- Director, Payment Integrity

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[redacted]

- Senior Program Manager
- Manager, Grievances and Appeals
- Senior Quality Analyst, Grievances and Appeals
- Senior Compliance Analyst, Grievances and Appeals
- Manager, Provider Relations
- Senior External Client Relations Manager
- Director, Customer Service
- Director, CC
- Director, UM
- Director, Quality
- [redacted] Compliance Officer
- Lead Risk and Compliance Case Manager

Overall Assessment

The grievance system follows standard processes. Grievances can be received from members, member representatives, or providers orally through Member Services or through an [redacted] staff member (e.g., the Member Advocate), or be written (i.e., filling out a form on the [redacted] website and sending it in). If a grievance is received orally, the Grievance coordinator completes a member grievance form and begins documenting the process. In June 2021, the Appeals and Grievance Department implemented a new process to determine whether a

grievance is an issue of quality of care versus quality of service. When a grievance is received, it is reviewed by a registered nurse (Clinical Nurse Reviewer) to reduce the number of grievance categories previously identified as "other". Once a determination is made by the Clinical Nurse Reviewer, the case is assigned to a grievance analyst who follows the case through resolution and notification.

Grievance staff take the lead on investigations, sending acknowledgement letters to members, sending letters and faxes and/or making calls to providers to obtain information regarding the grievance. Depending upon the nature of the grievance, other [redacted] departments may be involved in the investigation and resolution process. For instance, Provider Relations will be sent quality of service grievances and Provider Contracting will be sent vision grievances; the Quality department will be sent quality of care issues and other clinical issues. If both quality of care and quality of service issues are identified from the original grievance, a new unique ID is assigned to the respective investigation essentially creating two grievance cases that are attributed to the Member ID. This new process appears to be leaving open feedback loops and potentially creating confusion for the member about whether an investigation has been completed and by whom. Additionally, parsing out a grievance to multiple departments for review does not promote effective grievance CM and may be a disservice to the member.

Similar to grievances, standard appeals are accepted both orally (through Member Services) or in writing (through a form on the [redacted] website or through the form on the last page of the member's NOABD letter) and sent to [redacted]. Oral appeals, or appeals filed by providers, are required to have written member consent to move forward with the appeal process. The appeal process start date is the date the written appeal is received or the date the oral appeal is received, if written member consent is received within 10 calendar days from initial filing. Following CMS updates to the Final Rule effective December 14, 2020, [redacted] no longer requires written member consent for appeals filed by the member.

Appeals analysts are responsible for sending out member correspondence including the initial acknowledgement letter, letters requesting additional information, and the resolution letter, as well as calling and/or faxing providers. If continuation of current services is requested while the appeal is pending, the analyst checks to ensure the proper steps have occurred and timelines are met. If an appeal hearing is requested, the member or member representative is invited to attend in person or by phone. The Member Advocate also attends, along with the Standing committee. Hearings are held weekly. The member or member representative may present the case and answer questions. The case is deliberated, and a decision is made and communicated to the member within two business days.

In addition to the opportunities listed below, [redacted] should consider reviewing their P&Ps around oversight of delegated or subcontracted entities. During this review, evidence of a high rate of overturned appeals, before going to the hearing committee, emerged. For instance, [redacted] is granted initial UM decision making authority for the approval of high cost imaging services. Even though [redacted] and [redacted] use the same clinical

guidelines to determine medical necessity, there were a large number of files that exhibited overturned appeals by [redacted]. This would suggest a flaw in the initial UM decision process by [redacted] and does not reflect the member and provider-centric intentions of the [redacted] contract. Further information on the UM process can be found in Section 6: Clinical Practice Guidelines and Coverage and Authorization of Services of this report.

Grievance File Review

The grievance file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 grievance files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. Grievance subjects included categories such as access/availability of care, communication/relationships, transportation, quality of care, and others. The files were assessed for compliance with BBA regulations, State contract requirements, and [redacted] internal policy standards. The following elements were included in the review:

- Documentation of member correspondence and grievance details.
- Accuracy of classification and named provider.
- Grievance investigation and resolution.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.
- CC/continuity of care.

The assessment of the grievance files consisted of a review of the member's original grievance, internal notes and documents, letters produced by [redacted], and other documents supporting the investigation. Five of 30 grievance files were found to not be fully investigated prior to

issuing a final grievance resolution letter. For example, in unique ID # G20351363453 (regarding a quality of service issue) a decision letter was sent to the member stating, "You will receive a separate decision letter regarding your concerns about the care you received". Four other case files identified as either quality of care or quality of service had similar messaging. During the interviews with the MCO, it was explained that the case that was selected was a piece of a larger grievance file. When the original grievance was filed, three quality of care and three quality of service issues were identified and the original grievance broken into six for independent investigations and resolution, with six different unique IDs. [redacted] sent the other five sections of the grievance for Mercer to review. Each of the additional case files demonstrated the same language in the resolution letter stating that another department was completing the investigation and a separate resolution letter would be sent. There was no evidence that this grievance was fully investigated and appropriately resolved. Overall, the files reviewed were found to have between 75% and 89% compliance in the required elements.

Appeal File Review

The appeal file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 appeals files was selected for review, representing Medicaid, CHIP, and DSHP Plus membership. The sample contained appeals that were upheld, overturned, and withdrawn following or prior to the Appeals committee meeting. One expedited appeal was reviewed. The files were assessed for compliance with BBA regulations, State contract requirements, and [redacted] internal policy standards. The following elements were included in the review:

- Documentation of NOABD, member appeal, member consent, and supplemental information submitted by member or member's provider.
- Timely filing based on the NOABD date.
- Timely acknowledgement.
- Timely resolution.
- Timely notification of resolution.
- File completeness.

The assessment of the appeals files consisted of a review of NOABD letters, internal notes and documents, letters produced by [redacted], and other documents supporting the appeal investigation. Five of 30 appeals files were found to be missing written consent from the member when a provider or representative filed an expedited appeal on the member's behalf. During the interviews with the MCO, it was explained that the MSA states that member's written consent is not needed in this circumstance. After further discussion, it was determined that not requiring member written consent when a provider or representative files and appeal on behalf of the member does not align with federal regulations and the MCO must adhere to what is federally required. Other aspects of the file review evidenced that documents and timelines were met according to BBA and contract regulations. Overall, the files reviewed were found to have between 75% and 89% compliance in the required elements.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has a process to evaluate the compliance of its delegates responsible for adjudication of a grievance and appeals. Delegation oversight tools and file review clearly demonstrate evaluation of the delegates grievances system for compliance with federal requirements including: grievance system structure, accurate definitions, rural exceptions, adverse benefit determination language, resolution timeframes, expedited appeal processes, how information is shared with provider, continuation of benefits, and effectuation of reversed appeals. (42 CFR 438.400 (Sub-part F) and 5.1.2.2)	Not Met	The MCO does not have a tool or process to evaluate the compliance of its delegates responsible for adjudication of a grievance and/or appeals.	Develop a process and tools for structured oversight of delegated grievance and appeals activities.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has a process to ensure that all quality of care and quality of service grievances are fully investigated prior to issuing final grievance resolution. (3.13.3)	Partially Met	As evidenced during grievance file review, the MCO does not fully investigate quality of care and quality of service grievances prior to issuing final grievance resolution letters to the members.	Develop P&Ps to ensure all quality of care and quality of services grievances are investigated fully prior to the issuance of resolution letters to members.
Expedited authorization decisions are provided as expeditiously as the member's health condition requires and no longer than 72 hours after receipt of the request to make a decision. Period could be extended for 14 days under the same circumstances as apply for standard decisions if the MCO/BH-MCO extends the timeframe, it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires. (42 CFR 438.210(d)(2) and 3.12.6.5.2.3)	Partially Met	Appeals file review evidenced member's written consent was not included in the case file when a provider or representative filed an expedited appeal on the member's behalf.	Develop P&Ps to align with federal regulations and ensure providers/representatives receive member's written consent when filing an expedited appeal on the member's behalf.

[redacted]

8

Compliance with Federal Regulations for Medicaid Managed Care and State Standards — Certifications and Program Integrity

Program Integrity Requirements and Confidentiality

The following federal regulation is addressed in this section: 438.608 (a–b).

The intent of this regulation is to ensure appropriate safeguards for the MCO to guard against fraud and abuse. The MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, designed to guard against fraud and abuse. The MCO must have a designated compliance officer and compliance committee accountable to senior management, written P&Ps that accurately spell out the compliance process, effective training and lines of communication, enforcement standards, disciplinary guidelines and provisions for internal monitoring, reporting, and corrective actions.

The following federal regulation is addressed in this section: 438.224.

The intent of this regulation is to ensure the MCO has processes to protect medical records and any other health and enrollment information that identifies a particular enrollee and ensures that the uses and disclosure of such individually identifiable health information is in accordance with federal privacy requirements to the extent that these requirements are applicable.

To evaluate [redacted]'s compliance with federal regulations and contractual requirements regarding privacy, confidentiality, and prohibited affiliations with individuals debarred by federal agencies, Mercer conducted a thorough review of [redacted]'s policies, procedures including [redacted]'s Code of Conduct, audit work plans, and other training and compliance materials submitted in response to the RFI. This review was conducted based on information submitted by [redacted] through the RFI and onsite meetings on August 10, 2021–August 12, 2021. The onsite meeting included key leadership from the MCO including but not limited to:

- SVP, Medicaid Markets
- VP, [redacted] Markets, CEO
- VP, Operations, COO
- VP, Medicaid Business Management
- VP, Medicaid Service Operations
- VP, Medicaid Business Solutions
- VP, Finance, CFO [redacted]
- Director, Provider Experience
- Director, Member Experience
- Director, Payment Integrity
- Manager, Grievances and Appeals

Overall Assessment

[redacted] has well-documented Compliance and Program Integrity programs consisting of an annual written Compliance Program and work plan, a defined audit approach, and other data mining activities as well as, a corporate Code of Conduct and required annual training on compliance, confidentiality and privacy, and program integrity. [redacted]'s website ([redacted], Member Handbook, and Provider Manual all include language on what constitutes fraud, waste, and abuse, including an expanded definition of abuse

that incorporates abuse, neglect, and exploitation of children and adults. Multiple reporting channels are provided and include telephone and links to the Office of the Inspector General; all allow anonymous reporting. Internally, [redacted] staff can report suspected cases via an email box, tip line, or by bringing an issue to a manager; non-retaliation policies for good faith reporting are in place.

[redacted] has a dedicated Compliance Officer, who has a direct reporting relationship to the Board of Directors and is matrixed to the [redacted] market CEO. All [redacted] staff and contractors are assigned Compliance and Security trainings upon hire and annually thereafter. Completion of required training is tracked and monitored. When necessary non-compliant staff and contractors are escalated to managers and supervisors to ensure training is completed or the associate or contractor is terminated. In addition to guidance received in the Member Handbook, [redacted] includes a Notice of Privacy Practices on its website ([redacted]).

[redacted] has appropriate processes in place to protect member medical records and other health and enrollment information. Corporate policies clearly outline what constitutes Protected Health Information (PHI) and Personally Identifying Information (PII) and provide members with a formalized process by which access to health records for review and revision, including instances where such information would not be shared; all appear in compliance with federal regulatory requirements. [redacted] uses the State required file format to report breaches in confidentiality to the State and has adopted a [redacted] specific policy for reporting that reflects the required timeframes for reporting to the State.

Program integrity activities occur within the local [redacted] MCO with linkages to the [redacted] Compliance Officer. Staff work closely with local [redacted] leadership and the State to identify and share information pertaining to potential instances of fraud, waste, and abuse. Training on what constitutes fraud, waste, and abuse is given upon hire and annually thereafter. Tracking compliance follows a similar process as that described for Privacy and Confidentiality training above.

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.

Prohibited Affiliations with Individuals Debarred by Federal Agencies

The following federal regulation is addressed in this section: 438.610 (a–d).

The intent of this regulation is to ensure the MCO has processes in place to guard against knowingly entering into a relationship with an individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded by federal regulation from participating in federal procurement or certain non-procurement activities.

To evaluate [redacted] compliance with federal regulations and contractual requirements regarding prohibited affiliations with individuals debarred by federal agencies, Mercer conducted a thorough review of [redacted]'s P&Ps including [redacted]'s Code of Conduct. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite meetings held August 10, 2021–August 12, 2021. The virtual onsite meetings involved key leadership from the MCO including but not limited to:

- SVP, Medicaid Markets
- VP, [redacted] Markets, CEO
- VP, Operations, COO
- VP, Medicaid Business Management
- VP, Medicaid Service Operations
- VP, Medicaid Business Solutions
- VP, Finance, CFO [redacted]
- Director, Provider Experience
- Director, Member Experience

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- Director, Payment Integrity
- Manager, Grievances and Appeals

Overall Assessment

[redacted]'s credentialing unit within the Provider Information Management department is responsible for performing initial and ongoing (monthly) checks of all network providers, and Corporate Audit validates internal staff members. By contract, the State requires the MCOs perform monthly checks against List of Excluded Individuals/Entities (LEIE), Excluded Parties List System/Excluded Parties List System (SAMS/EPLS), and the SSA DMF. Additionally, ownership disclosure information is collected at the time of credentialing and annually thereafter, and those entities who hit the threshold are shared with [redacted] for further review and follow-up. There are clear processes to terminate network providers, vendors, and employees who are flagged as part of [redacted]'s systematic evaluation process.

Flow-down requirements to ensure prohibited affiliation monitoring and oversight are in place attach to [redacted]'s vendors and credentialing delegates and are evidenced in [redacted]'s submitted vendor contract templates, delegation audit tools, and evaluated during initial/annual delegation oversight audits.

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.

9

DSHP Plus Case Management

The Contractor shall provide CM to DSHP Plus LTSS members. The program provides services, including LTSS, through a managed care delivery system to DSHP Plus members that meet NF level of care or are "at risk" for NF level of care, DSHP Plus members who meet the hospital level of care criteria and have HIV/AIDS, and DSHP Plus members under age 21 years who meet NF level of care and reside in a NF.

To evaluate [redacted] compliance with contractual requirements regarding provision of CM to DSHP Plus LTSS members, Mercer conducted a thorough review of [redacted]'s policies, procedures, and supporting documentation. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite meetings held August 10, 2021–August 12, 2021. The virtual onsite meetings involved key leadership from the MCO including but not limited to:

- CMO
- Senior Project Manager
- Manager, Vendor Management
- Senior External Client Relations Manager
- Manager, Data Analytics
- Director, LTSS
- Medical Director

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- Manager Accreditation Monitoring and Quality Compliance, LTSS
- Program Manager, LTSS CM
- Manager, CCC
- Supervisor, Training and Development
- Supervisor, LTSS CM
- Manager, Risk and Compliance CM

Overall Assessment

The MCO has a strong and effective infrastructure for the CM program inclusive of processes, workflows, job aids, and desk level procedures, which support ongoing operations and ensure contract requirements are met. There is a strong training plan in place, addressing both initial and ongoing training. The MCO CM program benefits from consistent and competent leadership and MCO case managers demonstrate a strong commitment to improving the lives of Medicaid members. The MCO also demonstrates a commitment to the provision of housing supports and to meeting LTSS member dental needs.

The MCO demonstrated assertive outreach and support during the COVID-19 PHE and has begun the process of reinstating community-based face-to-face CM visits.

The MCO demonstrated emerging auditing and oversight processes and use of case file findings to address individual and systemic issues. There is a need for the MCO to continue its efforts specific to member case file audits in order to continue to drive improvements regarding assessment, care planning, follow-up on identified member needs (including preventive care), and to ensure appropriate standards of documentation, including documentation of late entries made in member records. The MCO needs to develop a policy, based on generally accepted medical record documentation standards, to provide guidance for late entries made in member records.

DSHP Plus Case Management File Review

Mercer completed a review of DSHP Plus LTSS member files using the File Review Protocol outlined in Section 3. A sample of 30 files was selected for review, including five each of AIDS Waiver, critical incident, redetermination, transition, HCBS, and NF member files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the six domains identified on the standardized scoring tool:

- Timely outreach and engagement
- General member education and annual redetermination requirements
- Assessment of member needs, concerns, and follow-up
- Identification of and referrals for health-related social needs (HRSNs)
- Care plan development
- Coordination of care

Domains were scored as "substantially met" when all or most of the expectations for CM were reached and documented appropriately. Domains were scored as "partially met" when documentation reflected that some CM activity was demonstrated in documentation. Domains were scored as "not met" when documentation of required CM activities was not sufficient.

The preliminary findings were reviewed with [redacted] and [redacted] at the onsite interview and five member records were reviewed in the [redacted] system.

Of the 30 DSHP Plus LTSS member files reviewed, the overall average score was 85.1%. Overall scores ranged from 55% to 100%. Outreach and engagement, general requirements, and care plan development were the domains with the highest ratings (90% or greater). The HRSN and coordination of care domains also had strong ratings (80% to 90%). Seventy percent of the files achieved substantially met ratings for the assessment domain resulting in an overall rating of 73.3%.

The following chart displays the strengths and opportunities broken down by domain.

Review Area	Strengths	Opportunities
Outreach and Engagement	Member files routinely reflect race, ethnicity, and preferred language.	On one occasion, a member was not assigned to a case manager within the required timeframe.
General Requirements	Member files reflect routine provision of information regarding member rights, disaster planning, and health education.	The annual HCBS level of care evaluation reflected delays or inconsistencies in completion. The process for monitoring completion and review of completed comprehensive medical reports could be further clarified.
Assessment	Member files reflect consistent assessment of oral health needs, COVID-19 precautions, and equipment/home modification needs.	Timely reassessment and follow-up after ED visits and hospital admissions was not consistent. Clarification of the process and tools to be used for identification of prescribed opioids, [redacted], [redacted], methadone, or other controlled drugs would enhance consistency of effort.
HRSNs	Member files generally reflect robust housing supports.	Leveraging the InterRAI HC assessment of preventative care needs could assist with consistent follow-up for recommended screenings such as colonoscopies and mammograms.
Care Plan Development	The Plan of Care template and Home Safety Monitoring Checklist are comprehensive tools. Plans of Care reflect member centric goals and in-home respite services.	Training updates could address inaccurate timelines for intervention target date.
Coordination of Care	Member files reflect CM efforts to coordinate care with PCPs despite difficulty getting PCP engagement.	Coordination of care between Aids Waiver case managers and LTSS case managers did reflect some redundancies. A protocol documenting specifics related to working with children in the Division of Family Services custody could be beneficial for CM.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO ensures DSHP Plus LTSS member care plans are based on assessment of functional, medical, behavioral, environmental factors, and existing support systems. Input from providers is taken into consideration, with member-specific goals. The process includes a mechanism for member agreement/disagreement of care plan at initiation. (3.7.2.3.4-3.7.2.3.8)	Substantially Met	Member case file review findings suggest a need to ensure preventive care gaps are addressed in members' care plans.	Provide evidence, based on focused audits of CM member records, demonstrating member preventive care gaps are addressed in members' care plans.
There is a process to ensure the CM electronic record is complete and accurate, can be printed, and includes all required information. (3.7.2.6)	Partially Met	A number of member case files reviewed included late entries.	Develop a policy, based on generally accepted medical record documentation standards, to provide guidance for late entries. Provide evidence, based on focused audits of CM member records, demonstrating fidelity to generally accepted medical record documentation standards for late entries.
The MCO has processes for initial identification and reassessment of DSHP Plus LTSS members' needs, which facilitates integration of both PH and BH needs. This process includes mechanisms for linking members to needed services and community resources. (3.7.2.1.1)	Substantially Met	Results of member case file reviews evidence untimely completion of member reassessments and include inconsistent follow-up/discharge planning related to ED visits and hospital admissions.	Provide evidence, based on focused audits of CM member records, demonstrating fidelity to the process for timely reassessments and follow-up to ED visits and hospital admissions.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has an audit process to ensure LTSS case record documentation is in keeping with the requirements of 3.7.2.6.	Substantially Met	Audit results indicate documentation standards are met, with the exception of late entries found in LTSS member records. However, the MCO does not have a policy or procedure for generally accepted medical record documentation standards for late entries.	Develop a policy, based on generally accepted medical record documentation standards, for late entries identified via auditing. Provide evidence, based on focused audits of CM member records, demonstrating fidelity to generally accepted medical record documentation standards for late entries.

10

Care Coordination

Coordination and Continuity — Primary Care and Special Health Care Needs

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 CC 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.

All Member Level Coordination

For the contractor's entire member population, the contractor shall provide appointment assistance and linkage to covered services and non-covered services with the objective of facilitating member access to medically necessary services and identifying members who could benefit from wellness programs. In addition, with the objective of engaging members in wellness and healthy behaviors, the contractor shall maintain an up-to-date registry of all wellness, health education, disease management and self-management programs, and activities available to members and accepting new members.

Level 1 Resource Coordination

The contractor is required to actively assist providers in discharge planning for Level 1 members following acute episodes of care involving, at a minimum, one of the following services: inpatient psychiatric stay, ambulatory surgery, hospital inpatient stay, and rehabilitation facility services. In addition, the contractor shall actively engage members with low acuity non-emergent (LANE) use of the ED back to their PCP and identify barriers and coordinate the member's linkage back to primary care services.

Level 2 Clinical Care Coordination

Members eligible to participate at this level shall be determined by predictive modeling to be at the highest risk for adverse health outcomes. Members determined eligible for Level 2 may include those members who have multiple chronic conditions including SUD or comorbid PH and BH conditions, complex health conditions, complex service needs requiring supported CC, history of poor outcomes, utilization patterns that suggest inadequate linkage to primary and preventive care, or other indicators of high-risk or potential for poor health outcomes. For all Level 2 members, the contractor shall provide CCC. Members shall have the right to participate or decline participation in CCC.

To evaluate [redacted] compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of [redacted]'s P&Ps and supporting documentation. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite

meetings held August 10, 2021–August 12, 2021. The virtual onsite meetings involved key leadership from the MCO including but not limited to:

- SVP, Medicaid Markets
- CMO
- VP, Care Management
- Director, Member Experience
- Medicaid Member Advocate
- Manager, Data Analytics
- Manager, Customer Service
- Business Process Analyst
- Director, CC
- Manager, CCC
- Supervisor, CM
- Supervisor, Clinical QM — EPSDT
- Clinical Compliance Coordinator, CC
- Program Manager, CC
- [redacted] Compliance Officer

- Lead Risk and Compliance Case Manager

Overall Assessment

The MCO has a strong and effective infrastructure for the CC program inclusive of processes, workflows, job aids, and desk level procedures, which support ongoing operations and ensure contract requirements are met. There is a comprehensive CC training plan that addresses both initial and ongoing training. The MCO has maintained consistent and competent leadership for the CC program and the MCO resource coordinators and clinical care coordinators demonstrate a commitment to improving the lives of Medicaid members.

The MCO demonstrated assertive outreach and support during the COVID-19 PHE and has begun the process of reinstating community-based face-to-face CC visits, including visits with incarcerated members. The MCO has developed and implemented strong oversight and focused case file auditing processes and utilizes audit findings to address individual and systemic issues.

All Member Level Coordination

The MCO has increased HRA completion rates based on enhanced outreach and through incentive offers.

Level I Resource Coordination

The MCO is in the process of developing a plan for implementing the Coleman Discharge Planning Model in an effort to improve discharge and transition supports to members with complex needs. The MCO recently revised its risk stratification plan and methodology where the majority of revisions are in compliance with contract standards; however, the MCO needs to address gaps in the approach to risk stratification for members being discharged from inpatient PH and BH stays to ensure assignment to Level 2 CC when appropriate. The MCO also needs to evaluate the role and expectations of Level 1 resource coordinators to ensure they are not making clinical judgements that are beyond their scope of knowledge or expertise, particularly as it relates to member risk stratification.

Level 1 Resource Coordination File Review

Mercer completed a review of 15 Level 1 Resource Coordination files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the four domains identified on the standardized scoring tool: Outreach and Engagement, Coordination of Care, Condition Management and BH SUD, and HRSNs. Domains were scored as “substantially met” when all

or most of the expectations for resource coordination were reached and documented appropriately. Domains were scored as "partially met" when documentation reflected that some resource coordination activity was present. Domains were scored as "not met" when documentation demonstrated that resource coordination expectations were not reached. For members who were reached and declined resource coordination or who were unable to be reached, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as "Not Applicable" (N/A).The member files were submitted in a well-organized format.

The preliminary findings were reviewed with [redacted] and [redacted] at the virtual onsite interview. During the interview, two member records were reviewed in the [redacted] CC system and it was recommended they review a third case independently due to the medical complexity of the case.

Of the 15 Level 1 Resource Coordination case files reviewed, three members were successfully outreached, engaged, and able to be fully scored and evaluated. Eight members declined resource coordination, two were never reached, and two were initially reached, agreed to the program but then could no longer be contacted. Of the three fully scored cases, one scored 30%, one scored 58%, and the highest score was 85%. Many of the members had significant medical or BH conditions that appeared to be outside of the scope of practice for Level 1 Resource Coordination.

The following chart displays the findings by domains, identifying strengths and opportunities. Please consider that not all sections of the case files could be scored as some members were unable to be reached or declined to participate in resource coordination, thus the numerator of outreached and engaged members was very small.

Review Area	Strengths	Opportunities
Outreach and Engagement	The files demonstrated a great deal of outreach activities.	There were missed opportunities to outreach hospitalized members. There is a recurrent issue of needs being identified on the initial call and then subsequent efforts to engage or reach the member are unsuccessful, leaving needs unaddressed. The MCO may benefit from ensuring assistance is offered during the initial touch point to engage the member. Stratification was an issue in most of the cases reviewed. Many of the Level 1 cases were quite complex and could have benefited from a referral to level 2. While some cases were restratified numerous times, there was not any reference to previous outreach attempts or member participation/declination. Notes from resource coordinators often indicate a scripted process and an inability to understand the clinical picture, affecting their ability to refer appropriately.
Coordination of Care	One file demonstrated that the resource coordinator appropriately suggested a referral to LTSS. In another case, the UM department coordinated with the resource coordinator to help secure an appointment.	The files contained appropriate referrals and coordination; however, there was not documentation indicating confirmation of the referred services.
Condition Management and BH SUD	The 24 hours a day, seven days a week Nurse Line and Member Services phone number were provided to several members.	BH conditions were not routinely addressed; for instance, a 17 year old post-partum woman with a history of mental health counseling and an Edinburgh scale of 10 was not acknowledged as a concern or referred to treatment.
HRSNs	In one case, the resource coordinator assisted a new mother with receiving a pack and play through the [redacted] incentive program.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were then met.

Level 2 Clinical Care Coordination

The MCO has formalized the use of evidence-based disease management standards for CC and is working to reduce care coordinator ratios below the required level in order to allow care coordinators more time to address the needs of complex members. The MCO needs to continue its efforts to audit member files to ensure care coordinators are consistently utilizing disease management standards and to ensure member case files reflect appropriate assessment, care planning, follow-up to identified member needs, and documentation standards.

Level 2 Clinical Care Coordination File Review

Mercer completed a review of 15 Level 2 CCC files. The files were reviewed for compliance with contract standards and to evaluate the extent to which the cases successfully met the five domains identified on the standardized scoring tool: Outreach and Engagement, HRSNs, Assessment, Coordination of Care, and Care Plan Development. Domains were scored as "substantially met" when all or most of the expectations for CC were reached and documented appropriately. Domains were scored as "partially met" when documentation reflected that some CC activity was present. Domains were scored as "not met" when documentation demonstrated that CC expectations were not reached. For members who were reached and declined CC, the Outreach and Engagement domain was the only domain that could be assessed, so all subsequent domains were scored as N/A. For the members who were unable to be reached, the only domain that was able to be scored was Outreach and Engagement, so all subsequent domains were scored as N/A.

Of the 15 Level 2 CCC case files reviewed, nine were outreached, engaged, and able to be fully scored and evaluated. Three members declined CC, two were never reached although efforts were made to communicate with inpatient providers, and one person was reached and agreed to the program but was lost to follow-up. Of the nine fully scored cases, scores ranged from 25% to 100%.

The following chart displays the findings by domains, identifying strengths and opportunities. Please consider that not all sections of the case files could be scored as some members were unable to be reached or declined to participate in CCC, thus the numerator of outreached and engaged members was limited to nine individuals.

Review Area	Strengths	Opportunities
Outreach and Engagement	Members who were reached were largely agreeable to enroll in CC. The files demonstrated a great deal of outreach activities.	In many cases, members agreed to enroll in CC upon initial engagement, but then were unable to be reached consistently. Members are outreached when they restratify, which occurs frequently, but there is not reference to previous attempts to outreach or of member declining or participating in the program.
HRSNs	When screenings were completed, members were asked about food, transportation, housing, and other HRSNs and needs were documented. One case demonstrated assistance in arranging transportation through Logisticare.	While resources were provided when a need was identified in some cases, follow-up was not routinely provided to close the loop and ensure that the member had made contact with the resources provided and that the member's needs were then met.
Assessment	When members were engaged, care coordinators made attempts to complete the assessment.	Many scored cases had incomplete assessments due to inconsistent contact with members. Other assessments were not consistently dated, making it difficult to evaluate compliance with timeframes.
Coordination of Care	Several cases demonstrated coordination between the care coordinator and inpatient social workers for hospitalized members.	There is not consistent internal coordination between Level 1 Resource Coordination and Level 2 CCC programs. Members appear to stratify between Level 1 and Lever 2 without clear internal communication or acknowledgement of transition. Collaboration with PCP, BH SUD, and other providers was inconsistent in the scored cases. Lengthy wait for PROMISE services results in unmet BH needs and poor outcomes.

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[redacted]

[redacted]

Review Area	Strengths	Opportunities
Care Plan Development	Gaps in care were routinely identified.	Gaps in care were not adequately addressed beyond reminding the member that a test or screening was overdue. Most scored cases had incomplete plans of care due to inconsistent contact with the member. It was unclear if plan of care was shared with member or providers in some cases.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO's predictive model identifies eligible Level 1 members and includes the following conditions/factors: pregnancy, one or more chronic conditions, gaps in preventive care, comorbid PH-BH conditions, high inpatient utilization, polypharmacy, or high rates of LANE ED utilization. The MCO's predictive model identifies eligible Level 2 members and includes the following conditions/factors: multiple chronic conditions, complex service needs, history of poor outcomes, utilization patterns that suggest linkage to primary and preventative care, or other indicators of high risk or potential for poor outcomes. (3.6.2.2.2, 3.6.2.2.1)	Substantially Met	The MCO provided a revised risk stratification plan to [redacted]. The revised plan was discussed during the EQR and appears to meet [redacted] contract requirements with the exception of risk stratification for members who are being discharged from inpatient PH and BH admissions. Based on discussion with the MCO and member case file review findings, it appears members being discharged from inpatient PH and BH admissions are assigned to Level 1 Resource Coordination, including those who have multiple comorbidities and complex needs.	Provide clarification regarding stratification and assignment of members with multiple comorbidities and complex needs who require discharge/transition supports. Validate that the risk stratification plan ensures members who require discharge/transition supports are assigned to the appropriate level of CC. Provide evidence, based on focused audits of resource coordination member records, demonstrating fidelity to the process for ensuring members being discharged from inpatient PH and BH admissions are assigned to the appropriate level of CC.

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Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has developed a program to implement wellness programs within network providers and to train providers on wellness activities. The MCO has a [redacted] approved Wellness Provider Training plan. (3.6.3.2.3.4, 3.6.3.2.3.3)	Substantially Met	The MCO provided information about provider training specific to the Wellness Registry. The [redacted] approved Wellness Program Provider Training Plan was not submitted.	Submit the [redacted] approved Wellness Program Provider Training Plan.
The MCO has a process to utilize stratification results to identify members most appropriate for Level 1 Resource Coordination CC and such a process includes the ability to restratify a member to a higher level. (3.6.2.5)	Substantially Met	The MCO provided P&Ps outlining the process for assigning members to Level 1 Resource Coordination. However, member case file review findings suggest some members with multiple comorbidities and/or complex conditions are being assigned to Level 1 Resource Coordination.	Document the process for ensuring members with multiple comorbidities and/or complex conditions are being assigned to the appropriate level of CC and, when necessary, reassigned to a higher level of CC.
The MCO has P&Ps that indicate all initial outreach occurs within 15 days of member being identified as eligible; with a minimum of five attempts made within the first 90 days, including at least one documented face-to-face (or virtual) attempt. If after 90 days or member declines participation, the CCC notes all outreach attempts and can close the case. If the member is identified as high-risk, BH, or SUD, the MCO outreaches to [redacted], Division of Substance Abuse and Mental Health, Division of Developmental Disabilities Services, or other agencies or providers prior to closing the case. (3.6.3.4.4.2)	Partially Met	The MCO provided information about member case file audits focused on ensuring timeliness of outreach efforts, but indicated there is not a formal monitoring or reporting process in place to evaluate the extent to which outreach efforts comply with contract timeframes.	Provide the process for evaluating the extent to which outreach efforts comply with contract timeframes.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO's P&Ps require clinical care coordinators to outreach to eligible members within 30 calendar days to complete a comprehensive assessment (e.g., PH, BH, social, environmental, cultural, psychological needs) including input from the member's caregivers, family, PCP, and other providers as appropriate. All outreach and coordination efforts are documented within the member's file and demonstrate active and good faith efforts to incorporate provider involvement in CC activities. (3.6.3.4.5.1-3.6.3.4.5.3)	Substantially Met	The MCO provided information about the process and tools used to evaluate compliance with contract requirements for timely completion of member assessments. However, member case file review findings suggest there is a need to further assess the extent to which assessments are appropriately dated and completed within prescribed timeframes.	Provide evidence, based on focused audits of CC member records, demonstrating fidelity to timelines for completion of a comprehensive assessment for Level 2 CCC members.
Supervisors and Level 2 CCC staff receive reports to monitor timeliness of outreach efforts and consistency with outreach and contact timeframes and develop staff and/or departmental corrective actions, if necessary. (3.21.6.1.3)	Partially Met	The MCO provided information about member case file audits focused on ensuring timeliness of outreach efforts, but indicated there is not a formal monitoring or reporting process in place to evaluate the extent to which outreach efforts comply with contract timeframes.	Provide the process for evaluating the extent to which outreach efforts comply with contract timeframes.

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Dental

The contractor shall provide access to dental services for members age 21 and older as described in the State's Medicaid State Plan.

To evaluate [redacted] compliance with contractual requirements regarding dental services, Mercer conducted a thorough review of [redacted]'s policies, procedures, and supporting documentation including dental program management structure, program highlights and updates since the October 1, 2020 go-live date, and P&Ps to address issues or concerns identified during the readiness review. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite meetings held August 10, 2021–August 12, 2021. The virtual onsite meetings involved key leadership from the MCO including but not limited to:

- Plan COO
- Provider Network Staff
- Dental Benefits Management (DBM) Staff
- Network Management Staff
- Claims and Encounters Staff
- Call Center Staff

The following areas were reviewed to determine [redacted]'s compliance with federal regulation, contract expectations, and MCO P&Ps.

- Department organizational structure
- Training
- Delegation
- Dental coverage provisions
- Cost sharing and member financial responsibility
- Transition of members
- Dental provider network
- UM
- Call center and website
- Dental grievances and appeals

Overall Assessment

On September 21, 2020, Mercer conducted a readiness review of [redacted]'s ability to effectively delivery a new dental benefit for the State's adult Medicaid population. A post-implementation review was planned for Quarter 1, 2021. To complete a post-implementation review, [redacted] requested that Mercer conduct the review as part of the annual BBA review and include data through Quarter 1, 2021.

Of the four opportunities identified during the readiness review, none remain unaddressed. [redacted] receives member grievances through the call center and forwards a service form to [redacted] for follow-up and resolution. As part of vendor oversight, [redacted] should ensure that member grievances received by [redacted] are recognized for tracking and trending purposes by [redacted]. As of the date of the virtual MCO interviews, [redacted] had not conducted an audit of [redacted]'s call center to ensure that all grievances are being identified and handled appropriately. Based on virtual

onsite interviews the following items do not warrant a CAP, however [redacted] and [redacted] should review P&Ps, and provider educational materials for consistency and applicability to the State's adult dental program. For example:

- [redacted] Medical Assistance Program Dental Reference Guide (Revised for January 2021) contains a list of adult benefit coverage benefits and limitations that contain information related to [redacted]'s corporate fee-for-service policy.
- United Concordia PPO/CMS Credentialing Policy and Procedure Manual timelines should be updated to align with the MSA (e.g., signed attestation no older than 180 days, and credentialing process completed within 60 days).
- Medicaid Member Complaint (Quality of Care) Policy and Procedure Manual — [redacted], MMC.003 — Appeals, definition reads: An appeal occurs when any member, or person acting on the member's behalf, aggrieved by a decision regarding a complaint formally requests reconsideration. The term complaint is not applicable to the MSA.

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.

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Pharmacy

The contractor shall provide access to outpatient pharmacy services eligible for Medicaid coverage as defined under Section 1927 of the Social Security Act and as described in the State's Medicaid State Plan.

To evaluate [redacted] compliance with contractual requirements regarding pharmacy services, Mercer conducted a thorough review of [redacted]'s policies, procedures, and supporting documentation including Pharmacy department structure, program highlights and updates since the 2020 review, and a selection of PA case files. This review was conducted based on information submitted by [redacted] through the RFI and through virtual onsite meetings held August 10, 2021–August 12, 2021. The virtual onsite meetings involved key leadership from the MCO including but not limited to:

- CMO
- Director, Pharmacy
- Supervisor, Pharmacy
- Pharmacist
- Account Manager, Regional PBM
- Senior Consultant, Compliance
- Analyst, Compliance

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- Senior Program Manager
- Pharmacy Product Associate
- Strategic AE

The following areas were reviewed by the pharmacy review team to determine [redacted]'s compliance with federal regulation, contract expectations, and MCO P&Ps.

- Department organizational structure and committees
- Drug utilization review, PAs, point-of-sale edits and audits
- Subcontractors
- General coverage provisions
- Cost sharing and medication therapy management
- Member services
- Network
- Call center and website
- Claims management
- Reporting

- Care management

Overall Assessment

Mercer finds [redacted] continues to administer a strong and member-focused pharmacy program. The pharmacy staff and contractor are fully engaged, both internally and with [redacted] staff.

During this year's virtual onsite review, [redacted] provided knowledgeable and accessible staff for the review. Mercer performed a complete compliance review, reviewing the full depth and breadth of the pharmacy program, including but not limited to staffing, reporting, pharmacy coverage provisions, customer service, website, PA file review, systems, and improvement initiatives. Overall, Mercer found little for concern. PA file review identified small areas for improvement in member communications, although overall provides support that [redacted] has a well-managed pharmacy program.

Strengths of [redacted]'s pharmacy program include the continuation of the [redacted] initiative and new [redacted] initiation activities.

The Opioid pod is a targeted member- and provider-level outreach program, intended to improve care surrounding opioid prescribing for members most at risk of adverse health effects due to opioid over-prescribing, unsafe drug combination prescribing, and lack of [redacted] prescribing. Pod staff may recommend a number of changes, including titration of opioid dosages, BH visits, tapering and discontinuation of benzodiazepines, alternative pain management strategies such as physical therapy and/or chiropractic visits, and [redacted] prescriptions. A weekly report is shared with [redacted] for members confirmed to be tapering opioid or interacting medications,

[redacted] has worked to improve [redacted] co-prescribing for members with high-dose opioids through the Opioid pod program. They have expanded these efforts by implementing point-of-sale messaging at the pharmacy for members with high dose opioids, leveraging the standing order in [redacted] that allows pharmacists to dispense [redacted]. Forthcoming [redacted] reporting will assess this new effort.

Pharmacy Prior Authorization File Review

The PA file review was performed using the File Review Protocol methodology outlined in Section 3. A sample of 30 PA files was randomly selected for review and included approvals, denials, and dismissals. The files were assessed for compliance with federal regulations, State contract requirements, and [redacted] internal policy standards. The following elements were included in the review:

- Documentation of member and provider details.
- Medication requested and proper criteria used for decision making.
- Timely resolution.
- Timely notification of resolution.
- Letter language to prescriber and member.
- File completeness.

Overall, 10 of the 10 files reviewed were found to have greater than 90% compliance in the required elements. Previous areas of concern surrounding language in the NOABD letters has been fully resolved.

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO has a PA policy that is compliant with Social Security Act §1927 and all provisions of section 3.5.9.1 of the MSA. The process explanation and documentation includes criteria, flow charts, and supporting tables. Non-preferred/restricted drugs are available with PA. The MCO has an effective and organized PA request queue, with all reviewer comments archived and timestamped. The MCO has a process to inform via Notice of Action within 24 hours. (3.5.9.1)	Partially Met	[redacted] PA process are timely, well documented, and compliant with minimum standards outlined in section 3.5.9.1 of the MSA. However, current PA denial letters continue to incorrectly reference the term "medical necessity" resulting in misleading or incorrect reasons for denial.	Adjust language in PA letters and provide documentation that all system and process updates reflect these changes.

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[redacted]

Regulation/Contract Standard Not Fully Compliant	2021 Review Score	Finding	Recommendation
The MCO provides reporting to satisfy the Pricing Transparency and Reporting requirements in 3.5.16.2 of the MSA.	Partially Met	The transparency reporting initiative has stalled, leading to no finalized reporting that has so far satisfied this contract requirement. The MCO stated in the RFI response that examples of transparency reports are available upon [redacted] request.	Finalize the Pharmacy Transparency Reporting template, and submit completed reporting.

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Validation of Performance Improvement Projects

Objective 1 — To assess the methodology applied by [redacted] for conducting a PIP.

Objective 2 — To evaluate the overall validity and reliability of PIP results.

Objective 3 — To assess compliance with state-required specifications.

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. [redacted] has mandated that each MCO conduct a minimum of five PIPs; the PIP topics must cover the following:

- Oral health of the LTSS population (this PIP is prescriptive in nature)
- BH and PH integration
- Pediatric population
- LTSS population
- Non-clinical or service related

Of the five required PIPs, the State required the EQRO to validate three PIPs during the 2020 compliance review cycle. The first PIP was the state-mandated study topic and study question (oral health of the LTSS population). The second PIP was a state-mandated topic but MCO developed study questions (BH and PH integration). The third required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by [redacted]. [redacted]'s selected topic focused on improving the rate of completion of HRA within 60 days.

The PIPs and the specifications to be applied included:

- Oral health for DSHP Plus LTSS members — state-developed specifications
- PH and BH CC — MCO-developed specifications
- HRA Standards

To evaluate [redacted]'s PIPs, Mercer reviewed the QI activity documents and facilitated a discussion of the measurement year (MY) during the virtual meetings held August 10, 2021–August 12, 2021. The PIP discussion engaged key leadership from the MCO, including but not limited to:

- CEO
- Executive Medical Director
- Medical Director
- VP, Government Compliance
- Director, Quality
- Director, IT Business Solutions
- Manager, Clinical Quality and Compliance
- Manager, Clinical Performance Measurement

- Manager, Data Analytics
- Senior Clinical QM Analyst
- Senior Decision Support Analyst, Quality
- Project Manager, Quality
- Compliance Analyst, Government Compliance
- Clinical QM Nurse Coordinator

Review Methodology

The summary results and recommendations presented below are based on EQR PIP Validation Protocol Steps 4–10 which include:

- Review the sampling method.
- Review the selected PIP variables.
- 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.
- Perform overall validation and reporting of PIP results.

The EQRO provides and 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 significant 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.

Overall Results

As noted earlier in this report, the [redacted] Quality department has faced challenges in leadership and staffing over the past several years, including the review period of 2020 as evidenced by quantifiable measure results and the confidence in reported results. The majority of interventions implemented have been passive in nature (e.g., newsletter articles, mailings, etc.), which have not resulted in the improvement intended with PIPs. The MCO must take a more aggressive approach to developing innovative interventions that show active engagement with members and community partners. At the time of the review in 2021, the EQRO and [redacted] are cautiously optimistic that [redacted] now has the resources and team to focus efforts particularly as it relates to PIP. Specifically, the Manager of QI, Regulatory, and Accreditation exhibited a strong base knowledge to identify PIP topics, develop an appropriate question, select quantifiable lead and lag measures, and implement and assess interventions all of which are supported by enhanced analytics.

PIP	Confidence in Reported Results
Oral Health for DSHP Plus LTSS members	Low
PH and BH CC	Low
HRA	Moderate

Oral Health for DSHP Plus LTSS Members

1. General PIP Information
Managed Care Plan (MCP) Name: [redacted]
PIP Title: DSHP Plus Oral Health
PIP Aim Statement: Would educating HCBS and skilled nursing facility (SNF) providers on the importance of daily oral care increase the number of members receiving regular oral care?
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)* ☒ Adults only (age 18 and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**: N/A
Target population description, such as duals, LTSS, or pregnant women (please specify): DSHP Plus LTSS population
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) • The focus of this PIP is to determine if provider education on oral health care would affect the care of members at home and at NFs of the LTSS population. – In fall 2020, an article was placed in the member newsletter, "Oral Health = Total Health." – In October 2020, a flash link was placed on the member website to announce the dental benefit changes. – In winter 2020, an announcement was placed in the member newsletter to alert member of the enhancement of the dental benefits for adults, as well as children under 21 "Adult Dental Benefits Exclusions and Limitations."
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach) • In the fall Provider Update Article "Oral Health Is Everybody's Business" alerting the providers to link and review the educational video to stay updated on proper oral health. This is an educational video, which on completion of an attestation, the provider may receive flip cards with vital oral heal information.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools) • Quarter 1 2020: Provider oral health toolkit is in its first full quarter of circulation, via Member Advocates and Community Health Workers. • Quarter 2 2020: Revised study questions to represent the correct population, targets, and timelines (as applicable); Revised all measures to ensure that metrics (numerators/denominators) are quantifiable and will answer the hypotheses posed in the study question. Confirmed all data sources are readily accessible and the best source of truth for each metric; and Set up monthly reporting to ensure close and effective monitoring, tracking, and trending of the data. • Quarter 3 2020: Met with analytics team and LTSS team to discuss the way the data was being pulled. [redacted] found several areas where data can be pulled in a more comprehensive manner. Based on these ongoing meetings, metrics have been reviewed to assure appropriate data capture. PIP Data reporting will now take place monthly.

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [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**
Lead 1: Percentage of HCBS providers who have been educated about the importance of daily oral health care.	2019	Sample size based on denominator. Denominator: 41 Rate: 17.1%	Quarter 3 2020	Quarter 3 2020 Sample Size: 58 Rate: 0/58 (0%) Goal: 42% PIP retired fourth Quarter 2020	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: Percentage of SNF providers who have been educated about the importance of daily oral health care.	2019	Sample size based on denominator. Denominator: 41 Rate: 17.1%	Quarter 3 2020	Quarter 3 2020 Sample Size: 41 Rate: 0/41 (0%) Goal: 42% PIP retired fourth Quarter 2020	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 3: Percentage of DSHP Plus LTSS HCBS members, including those in assisted living, who have home health care/attendant care and have daily oral care documented as an intervention on the agency care plan.	2018	Sample size based on denominator. Denominator: 997 Rate: 75%	Quarter 3 2020	Quarter 3 2020 Sample Size: 3414 Rate: 3029/3414 (91.56%) Goal: 90% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify): No baseline rate

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [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**
Lead 4: Percentage of DSHP Plus LTSS SNF members who have daily oral care documented as an intervention on the facility care plan.	2018	Sample size based on denominator. Denominator: 950 Rate: 85%	Quarter 3 2020	Quarter 3 2020 Sample Size: 1744 Rate: 1741/1744 (99.83%) Goal: 100% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 5: Percentage of HCBS DSHP Plus LTSS members, including those in assisted living, who report having been educated about the importance of daily oral health care.	2016	Sample size based on denominator. Denominator: 5,037 Rate: 71%	Quarter 3 2020	Quarter 3 2020 Sample Size: 3720 Rate: 3593/3720 (96.59%) Goal: 95% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 1: The Percentage of all DSHP Plus LTSS care plans that include meaningful and achievable (daily oral cleansing) oral health goals.	2018	Sample size based on denominator. Denominator: 5,037 Rate: 32%	Quarter 3 2020	Quarter 3 2020 Sample Size: 5730 Rate: 80/5730 (1.4) Goal: 10% PIP retired fourth Quarter 2020	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
PMs (be specific and indicate measure steward and National Quality Forum [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**
Lag 2: Percentage of DSHP Plus LTSS HCBS members, including those in assisted living, who report that they complete daily oral care (self-administered or through support services).	2016	Sample size based on denominator. Denominator: 5,037 Rate: 66%	Quarter 3 2020	Quarter 3 2020 Sample Size: 3720 Rate: 3515/3720 (94.49%) Goal: 97% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 3: Percentage of SNF DSHP Plus LTSS members who report to their care manager that they complete daily oral care (self-administered or through support services).	2016	Sample size based on denominator. Denominator: 2,516 Rate: 16%	Quarter 3 2020	Quarter 3 2020 Sample Size: 1744 Rate: 1723/1744 (98.8%) Goal: 100% PIP retired fourth Quarter 2020	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 4: Percentage of DSHP Plus LTSS HCBS members, excluding those in assisted living, who have home health care/attendant care, are not independent in oral care, and have daily oral care documented as an intervention on the agency care plan.	2018	Sample size based on denominator. Denominator: 862 Rate: 72%	Quarter 3 2020	Quarter 3 2020 Sample Size: 1891 Rate: 845/1891 (44.69%) Goal: 45% PIP retired fourth Quarter 2020	☒ 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): Multiple re-measurement periods for lead measures and lag measures that are based on quarterly data. **Validation rating**: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "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 significant evidence of improvement.
EQRO recommendations for improvement of PIP: The state-mandated PIP study topic and question was intended to include mandated quantifiable measures as well. [redacted] modified these measures, which limits the comparability between MCO results. For the measures [redacted] included, [redacted] demonstrated improvement in six of the quantifiable measures, but none of the improvement was statistically significant. [redacted] has retired this state-mandated PIP.

Behavioral Health and Physical Health Care Coordination

1.General PIP Information
MCP Name: [redacted]
PIP Title: BH and PH CC
PIP Aim Statement: Does the coordination of care interventions for adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis who also have a diabetes diagnosis, increase the number of members who had both the LDL-C test and an HbA1c test during the MY?
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.)

1. General PIP Information
Target age group (check one): ☐ Children only (ages 0–17)* ☒ Adults only (age 18 and over) ☐ Both adults and children ***If PIP uses different age threshold for children, specify age range here**: N/A
Target population description, such as duals, LTSS, or pregnant women (please specify): N/A
Programs: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach) • In spring 2020, an article was placed in the Member Newsletter. "How to Handle Low Blood Sugar." • In spring 2020, an article was placed in the Member Newsletter. "Lifestyle Management/Wellness Programs." • In fall 2020, an article was placed in the Member Newsletter. "Lifestyle Management/Wellness Programs." • In winter 2020, an article was placed in the Member Newsletter. "Diabetes Corner." • In winter 2020, an article was placed in the Member Newsletter. "Lifestyle Management/Wellness Programs."

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Provider-focused interventions (provider interventions are those aimed at changing provider practices or behaviors, such as financial or non-financial incentives, education, and outreach)
• In summer 2020, an article was placed in the Provider Update. "Preventing and Managing Hypoglycemia in Patients with Diabetes."
• In summer 2020, an article was placed in the Provider Update. "Links to Wellness Programs and Services."
• In summer 2020, an article was placed in the Provider Update. "Lifestyle Management/Wellness Programs."
• In fall 2020, an article was placed in the Provider Update. 'Diabetes Prevention for Behavioral Health Patients."
• In fall 2020, an article was placed in the Provider Update. "Help Us Help Our Members Prevent Diabetes."
• In fall 2020, an article was placed in the Provider Update. "Links to Wellness Programs and Services."
• In fall 2020, an article was placed in the Provider Update. "Lifestyle Management/Wellness Programs."
• In fall 2020, an article was placed in the Provider Update. "2020 Clinical Practice Guidelines."
• In winter 2020, an article was placed in the Provider Update. "Lifestyle Management/Wellness Programs."
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
• Quarter 1 2020: Quality team implemented a new BH-PH PIP Workgroup. This workgroup consists of an interdisciplinary team of staff: Clinical QM Analysts, Care Coordinators, BH CC Manager, and Medical Director, specializing in Psychiatry.
• Quarter 2 2020: Revised study questions to represent the correct population, targets, and timelines (as applicable). Revised all measures to ensure that metrics (numerators/denominators) are quantifiable and will answer the hypotheses posed in the study question; Confirmed all data sources are readily accessible and the best source of truth for each metric; and Set up monthly reporting to ensure we can closely monitor, track, and trend data effectively.
• Quarter 3 2020: Medicaid analytics has ensured that the metrics are quantifiable. [redacted] now closely monitors corrected population. By adding a third lag question, [redacted] can accurately monitor member compliance with HbA1c and LDL-C testing. [redacted] is now receiving monthly reporting from Medicaid analytics to monitor closely data efficacy. [redacted] has added Lag 3 to determine the impact of the intervention to see if members received both screenings (LDL-C and HbA1c).

3. PMs and Results (Add rows as necessary)						
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**
Lead 1: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services. (Elected is defined as those who have completed the task of an acquired and consent form.).	2020	Sample size based on denominator. Denominator: 85 Rate: 2.35%	Quarter 4 2020	Quarter 4 2020 Sample Size: 155 Rate: 17/155 (15.4%) Goal: 10%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services, and who are engaged in care. (Engaged is defined as members who have completed the following tasks: create care plan, HRA, coordination with PCP/Specialist or OB/GYN, patient self-management guide [PSMG], and a face-to-face intervention.)	2020	Sample size based on denominator. Denominator: 85 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 168 Rate: 6/168 (3.57%) Goal: 25%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
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**
Lag 1: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services, and who are engaged in CC, and who after receiving an intervention completed their LDL-C test.	2020	Sample size based on denominator. Denominator: 0 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 6 Rate: 2/6 (33.33%) Goal: 50%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lag 2: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services, and who are engaged in CC, and who after receiving an intervention completed their HbA1c test.	2020	Sample size based on denominator. Denominator: 0 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 6 Rate: 3/6 (50%)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
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**
Lag 3: Percentage of adult members 18–64 years of age with either a schizophrenia diagnosis or schizo-affective disorder diagnosis, who have elected CC services, and who are engaged in CC, and who after receiving an intervention completed both their HbA1C and LDL-C diabetic screeners	2020	Sample size based on denominator. Denominator: 0 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample size: 6 Rate: 2/6 (33.33%) Goal: 50%	☒ 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): **Validation rating**: ☐ High confidence ☐ Moderate confidence ☒ Low confidence ☐ No confidence "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 significant evidence of improvement.

4. PIP Validation Information
EQRO recommendations for improvement of PIP:
There is significant concern about the denominator size for this PIP; the small denominator size leads to statistical volatility. The denominator is based on the member's choice to engage in CC; the lack of engagement in CC has been noted in other sections of this report as a concern. Four of the five quantifiable measures demonstrated improvement; however, no improvement was statistically significant. This PIP faced particular challenges in 2020 due to the COVID-19 PHE; however, persistently [redacted] has employed passive interventions (e.g., provider and member newsletter articles, mailings) which have shown limited effectiveness.

Health Risk Assessment Standards

1. General PIP Information
MCP Name: [redacted]
PIP Title: HRA Standards
PIP Aim Statement: Would member advocate outreach initiatives for members who have been on the plan for 30 days or greater, with no completed HRA, lead to an increase in overall HRA completions?
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)* ☐ Adults only (age 18 and over) ☒ Both adults and children ***If PIP uses different age threshold for children, specify age range here**: 6 to 12 years old.
Target population description, such as duals, LTSS, or pregnant women (please specify): N/A
Programs: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP

2. Improvement Strategies or Interventions (Changes tested in the PIP)
Member-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
• In 2020, an article was placed in the Member Handbook, "Health Risk Assessment."
Provider-focused interventions (member interventions are those aimed at changing member practices or behaviors, such as financial or non-financial incentives, education, and outreach)
• None.
MCP-focused interventions/System changes (MCP/system change interventions are aimed at changing MCP operations; they may include new programs, practices, or infrastructure, such as new patient registries or data tools)
• Quarter 1 2020: Member Advocate were not performing HRAs currently.
• Quarter 2 2020: In 2020, [redacted] incorporated the recommendations of [redacted] that [redacted] categorize telephonic outreach and outcomes of the calls. Those outcomes include: number of outreach attempts where members were contacted, number of members who completed surveys, number of members refusing to complete survey, and number of members who had messages left on voicemail. The measures were updated to 30 days instead of the previous measure of 60 days. Revised study questions to represent the correct population, targets, and timelines (as applicable); Revised all measures to ensure that metrics (numerators/denominators) are quantifiable and will answer the hypotheses posed in the study question; Confirmed all data sources are readily accessible and the best source of truth for each metric; and Set up monthly reporting to ensure we can closely monitor, track, and trend data effectively.
• Quarter 3 2020: The process for completing the HRA has changed to disallow "partially completed" surveys; therefore, lead 4 will be removed in future submissions.
• Quarter 4 2020: Lead and Lag measures have been modified to reflect accurate measure of identified population. The interventions and the results of those interventions.

3. PMs and Results (Add rows as necessary)						
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**
Lead 1: The percentage of [redacted] members who received telephonic outreach by a Member Advocate after being identified as on the plan for 30 days, with no documented HRA, and now have a completed HRA.	2020	Sample size based on denominator. Denominator: 290 Rate: 19.2%	Quarter 4 2020	Quarter 4 2020 Sample Size: 2383 Rate: 790/2383 (33%)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 2: The percentage of [redacted] members who received telephonic outreach by a Member Advocate, after being identified as on the plan for 30 days with no documented HRA, but the advocate was unable to reach the member.	2020	Sample size based on denominator. Denominator: 290 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 2383 Rate: 1640/2383 (68.8%) Goal: 90%	☐ Yes ☒ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
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**
Lead 3: The percentage of [redacted] members who received telephonic outreach by a Member Advocate, after being identified as on the plan for 30 days, with no documented HRA, but the member declined outreach (refused to complete survey) from the Member Advocate.	2020	Sample size based on denominator. Denominator: 290 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 2383 Rate: 64/2383 (2.68%)	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):
Lead 4: The percentage of [redacted] members who received telephonic outreach by a Member Advocate, after being identified as on the plan for 30 days, with no documented HRA, but the HRA was only partially completed (not all qualifying questions are answered on the survey; one or more qualifying questions are unanswered/omitted).	2020	Sample size based on denominator. Denominator: 290 Rate: 0%	Quarter 4 2020	Quarter 4 2020 Sample Size: 290 Rate: 0/290 (0%) Goal: 0%	☒ Yes ☐ No	☐ Yes ☒ No Specify P-value: ☐ <.01 ☐ <.05 Other (specify):

3. PMs and Results (Add rows as necessary)						
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**
Lag 1: The percentage of [redacted] members who have completed a HRA within 60 days of enrollment.	2020	Sample size based on denominator. Denominator: 1,563 Rate: 13.95%	Quarter 4 2020	Quarter 4 2020 Sample Size: 790 Rate: 597/790 (75.50%) Goal: 50%	☒ 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): Multiple re-measurement periods for lead measures and lag measures that are based on quarterly data. **Validation rating**: ☒ High confidence ☐ Moderate confidence ☐ Low confidence ☐ No confidence "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 significant evidence of improvement.
EQRO recommendations for improvement of PIP: Four of the five quantifiable measures showed demonstrated improvement; however, none of the measures showed statistically significant improvement. This PIP challenges in 2020 due to the COVID-19 PHE; however, persistently [redacted] has employed passive interventions (e.g., provider and member newsletter articles, mailings), which have shown limited effectiveness.

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Validation of Performance Measures

Objective 1

Validate the accuracy of Medicaid, CHIP, and DSHP Plus PMs reported by [redacted].

To evaluate [redacted]'s compliance with federal regulations and contractual requirements, Mercer conducted a thorough review of [redacted]'s RFI response, consisting of policies, procedures, and supporting documentation. This review was conducted based on information submitted by [redacted] through the RFI and onsite meetings on August 10, 2021–August 12, 2021. The onsite meeting included key leadership from the MCO including but not limited to:

- VP, Medicaid Business Solutions
- VP, Care Management
- Senior Project Manager
- Vendor Management Analyst
- Director, Analytics
- Manager, Data Analytics
- Director, Care Coordinator
- Director, Quality

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- Director, UM
- Program Manager, CC
- Strategy Program Manager
- Manager, Clinical Performance Measurement
- Senior Decision Support Analyst, Quality
- Value-Based Performance Measurement Consultant
- Lead Risk and Compliance Case Manager
- Manager Accreditation Monitoring and Quality Compliance

Review Methodology

The PM review process included review of the written desk P&Ps that are followed when the reports and measure scores are generated. As a cornerstone of the review, the assessment and applicability of the CMS protocol entitled "Validating Performance Measures" was completed. This protocol's goal was guiding the assessment of the compliance with identified specifications applicable to each PM. The measures reviewed for 2021 included a combination of CMS adult and pediatric core measures, as well as Quality and Care Management Measurement Report (QCMMR) measures. To assess the compliance, some of the adult and pediatric core measures selected where relaying on the hybrid method to calculate the scores.

Overall Assessment

[redacted] has a process in place to generate the standardized reports to fulfill contractual obligations required by the [redacted]. The process differs between the HEDIS required reporting and reports and measures generated for Regulatory Reporting. [redacted] depends on the internal processes to assess data integrity and establish acceptable data quality. Internal teams such as analytics, quality, and UM collaborate together to

manage the development of data reports and/or products that enhance the overall performance of the business and monitor adherence to the timelines of regulatory reporting.

Business requirements and technical specifications are documented for each regulatory report. Any changes to technical specifications are routed through the Report Coordinator to facilitate the work. Monthly regulatory reports are completed by each functional area responsible for data within their given area, including subcontractors. Reports are developed by team members who populate the templates, review for variances (investigating any variances with a 10% variance from month-to-month), and draft any narratives. After the report development, department Directors review and validate the data, adjust narratives, and attest to the report. A Report Coordinator monitors submissions for timeliness, completeness, and accuracy working directly with functional areas and analytics if changes or additional explanations are needed. [redacted]'s COO is accountable for non-clinical content of the reports and the CMO attests to clinical topics covered in the reports.

Given the vast number of the reports, changes within the health care industry as well as changes within the [redacted] organization, developing a robust process of data governance, as noted during the Information Systems Capabilities Assessment (ISCA), could greatly benefit the MCO operation. For consistency, each data element used in the reporting should have clear definitions, acceptable values domains, a clear owner, and defined purpose and use. Additionally, on a regular basis (e.g., annually) all reports and data elements should be reviewed to ensure no changes are required to the reporting such as adding new CPT codes, provider taxonomies, and other health care nomenclature. Moreover, the review of the reports would allow [redacted] to determine if any changes based on the system changes (i.e., upgrades and enhancements) necessitate report modifications to account for these transformations.

[redacted] utilizes the NCQA certified HEDIS software, [redacted], for calculating all HEDIS PMs and this source code is considered fully compliant. [redacted] has a team comprised of management, technical, and clinical analysts to oversee the execution of the HEDIS project. Additionally, [redacted] contracts with a certified HEDIS data management vendor who receives and processes administrative and supplemental data and calculates rates for each of the measures in the HEDIS technical specifications. All claims, encounter, provider, and membership data is extracted from the electronic health record (the core claims processing solution), and loaded into the warehouse before being extracted and sent to the HEDIS data management vendor. Claims data from subcontractors including [redacted], [redacted], and [redacted] are loaded to the data warehouse before being extracted and sent to the HEDIS data management vendor. The data analyst and manager review the results from each data processing cycle against the results of previous cycles as a quality check. Any measure outside of the expected value (i.e., >2%) will be investigated to determine the root cause behind the change(s).

[redacted] engages [redacted], who uses the base HEDIS proprietary source code, to program and calculate the non-HEDIS Core Measures as well. The sampling process, tools, and IRR testing for generating hybrid measure results appear appropriate. The EQRO has a high level of confidence in the validity of the PMs generated using NCQA certified HEDIS software and nationally recognized specifications.

Compliance Findings

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.

Overall Results

PM	Confidence in Reported Results
PM 1: Adult PCPs with Closed Panels	Low confidence
PM 2: Provider Complaints	Low confidence
PM 3: Comprehensive Diabetes Control (Poor Control >9%)	High confidence
PM 4: Immunizations for Adolescents (IMA-CH)	High confidence
PM 5: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	High confidence
PM 6: Plan All Cause Readmissions (PCR-AD)	High confidence

Adult PCPs with Closed Panels

1. Overview of PM
MCP name: [redacted]
PM name: PM 1: Adult PCPs with closed panels
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): QCMMR
What data source(s) was used to calculate the measure? (check all that apply) ☐ Administrative data (describe): _____ ☐ Medical records (describe): _____ ☒ Other (specify): Credentialing Provider Repository (CPR) — Provider Data Source
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): In network Adult PCPs
Definition of numerator (describe): Number of adult PCPs with closed panels

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1. Overview of PM
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date): N/A

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**January 2020**	**June 2020**	**December 2020**	**Average Rate for 2020**
Numerator	17	26	28	24
Denominator	543	536	535	534
Rate	3%	5%	5%	4%

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). None to review.
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. There were no findings from the ISCA that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the PM results. ☒ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. In the initial submission, [redacted] did not include any rates for this measure. During the virtual onsite, [redacted] committed to submitting the completed rates. However, only selected rates were included as part of the follow-up documentation. Additionally, during the meeting, [redacted] was not able to explain what was or should be included as numerator and denominators nor was able to clearly articulate who is responsible for the measure, rate calculation, and how the values are used in the QI activities. Moreover, the notes, included in the follow-up documentation, indicate that there is no clear owner of the process to generate and monitor this measure. Mercer recommends the comprehensive review of the specifications to identify the owner of the measure and data elements used for the rate calculation.

3. PM Validation Status
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: Conduct a comprehensive review the specifications for the measure, identify the owner of the measure for review and reporting as well as those responsible for use of the measure for ongoing QI initiatives; ensure [redacted] received accurate and complete information.

Provider Complaints

1. Overview of PM
MCP name: [redacted]
PM name: PM 2: Provider complaints
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): QCMMR
What data source(s) was used to calculate the measure? (check all that apply) ☒ Administrative data (describe): Administrative complaints — emails, fax, and verbal ☐ Medical records (describe): _____ ☒ Other (specify): Reports pulled from INSINQ

1. Overview of PM
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): N/A
Definition of numerator (describe): N/A
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): Monthly

2. PM Results (If measure contains more than one rate, add columns to the table)	
PM	**Not Applicable for Provider Complaints**
Numerator	N/A
Denominator	N/A
Rate	N/A

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (e.g., deviations in denominator, numerator, data source, measurement period, or other aspect of the measure calculation). N/A
Describe any findings from the ISCA or other information systems audit that affected the reliability or validity of the PM results. There were no findings from the ISCA that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed)

3. PM Validation Status
Describe any findings from medical record review that affected the reliability or validity of the PM results. There were no findings from the medical record review that affected the reliability or validity of the PM results. ☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation. The initial submission did not include any numbers related to the provider complaints. The additional documentation including the specifications used for evaluation of the measure and extractions of the number were going to be submitted as part of the follow-up documentation. However, only internal notes were included in the submission and no meaningful and explanatory information has been submitted as part of the follow-up documentation. Mercer strongly recommends, [redacted] review the specifications for the measure, identify clear owner, and improve internal processes of clear delineation of the required mandatory reporting to ensure DMMS received accurate and complete information.
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: Conduct a comprehensive review the specifications for the measure, identify the owner of the measure for review and reporting as well as those responsible for use of the measure for ongoing QI initiatives; ensure [redacted] received accurate and complete information.

Comprehensive Diabetes Control (Poor Control >9%)

1. Overview of PM
MCP name: [redacted]
PM name: PM 3: Comprehensive Diabetes Control (Poor Control >9%)
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): _____

1. Overview of PM
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): HEDIS hybrid data medical record review campaign ☐ Other (specify): _____
If the hybrid method was used, describe the sampling approach used to select the medical records: Sampling based on HEDIS MY 2020 Specifications. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): Denominator compliance is applied in accordance with HEDIS MY 2020 Specifications.
Definition of numerator (describe): Numerator compliance is applied in accordance with HEDIS MY 2020 Specifications.
Program(s) included in the measure: ☒ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☐ Medicaid and CHIP
Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**Rate 1**	**Rate 2**	**Rate 3**	**Rate 4**
Numerator	151			
Denominator	411			
Rate	38.44%			

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (e.g., 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.
There were no findings from the ISCA that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the PM results.
There were no findings from the medical record review that affected the reliability or validity of the PM results.
☐ Not applicable (medical record review not conducted)
Describe any other validation findings that affected the accuracy of the PM calculation.
NCQA-Certified HEDIS Compliance Auditor examined [redacted]'s submitted measures for conformity with the technical specifications for Federal Fiscal Year (FFY) 2019 for the Adult Core Set. The audit followed the NCQA HEDIS Compliance Audit standards and P&Ps. Although this measure is HEDIS and has been certified by the HEDIS vendor, Mercer recommends [redacted] understand the detailed specification to ensure all the data extracts submitted for the rate calculation are correct. During the virtual onsite, [redacted] did not present full recognition of the measure specifications such as that measure applies to beneficiaries' ages 18 to 75, and for the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
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:
Submit rates for all age stratifications. Calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.

Immunizations for Adolescents (IMA-CH)

1. Overview of PM
MCP name: [redacted]
PM name: PM 4: Immunizations for Adolescents (IMA-CH)

1. Overview of PM
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): HEDIS hybrid data medical record review campaign ☐ Other (specify): _____
If the hybrid method was used, describe the sampling approach used to select the medical records: Sampling based on HEDIS MY 2020 Specifications. ☐ Not applicable (hybrid method not used)
Definition of denominator (describe): Denominator compliance is applied in accordance with HEDIS MY 2020 Specifications.
Definition of numerator (describe): Numerator compliance is applied in accordance with HEDIS MY 2020 Specifications.
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)					
PM	**Rate 1 — Meningococcal**	**Rate 2 — Tdap**	**Rate 3 — HPV**	**Rate 4 — CO1**	**Rate 5 — CO2**
Numerator	323	340	202	315	178
Denominator	411	411	411	411	411
Rate	78.59%	82.73%	49.15%	76.64%	43.31%

3. PM Validation Status

Describe any deviations from the technical specifications and explain reasons for deviations (e.g., 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.
There were no findings from the ISCA that affected the reliability or validity of the PM results.
☐ Not applicable (ISCA not reviewed)

Describe any findings from medical record review that affected the reliability or validity of the PM results.
There were no findings from the medical record review that affected the reliability or validity of the PM results.
☐ Not applicable (medical record review not conducted)

Describe any other validation findings that affected the accuracy of the PM calculation.
NCQA-Certified HEDIS Compliance Auditor examined [redacted]'s submitted measures for conformity with the technical specifications for FFY 2019 for the Child Core Set. The audit followed the NCQA HEDIS Compliance Audit standards and P&Ps.

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 Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

1. Overview of PM
MCP name: [redacted]
PM name: PM 5: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
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): Denominator compliance is applied in accordance with HEDIS MY 2020 Specifications.
Definition of numerator (describe): Numerator compliance is applied in accordance with HEDIS MY 2020 Specifications.

1. Overview of PM
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)				
PM	**Rate 1 — Initiation**	**Rate 2 — Continuation Phase**	**Rate 3**	**Rate 4**
Numerator	396	134		
Denominator	1032	279		
Rate	38.37%	48.03%		

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (e.g., 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. There were no findings from the ISCA that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the PM results. ☒ Not applicable (medical record review 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.

3. PM Validation Status
EQRO recommendations for improvement of PM calculation: None.

Plan All Cause Readmissions (PCR-AD)

1. Overview of PM
MCP name: [redacted]
PM name: PM 6: Plan All Cause Readmissions (PCR-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)

1. Overview of PM
Definition of denominator (describe): N/A
Definition of numerator (describe): N/A
Program(s) included in the measure: ☐ Medicaid (Title XIX) only ☐ CHIP (Title XXI) only ☒ Medicaid and CHIP
Measurement period (start/end date): January 1, 2020–December 31, 2020

2. PM Results (If measure contains more than one rate, add columns to the table)	
PM	
Numerator	N/A
Denominator	N/A
Rate/Observed versus Expected Ratio	1.12

3. PM Validation Status
Describe any deviations from the technical specifications and explain reasons for deviations (e.g., 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. There were no findings from the ISCA that affected the reliability or validity of the PM results. ☐ Not applicable (ISCA not reviewed)
Describe any findings from medical record review that affected the reliability or validity of the PM results. ☒ Not applicable (medical record review not conducted)

3. PM Validation Status
Describe any other validation findings that affected the accuracy of the PM calculation. Similar to the other HEDIS measures, Mercer recommends [redacted] become versed in the HEDIS measures, calculations, and use for QIs activities. During the virtual onsite, [redacted] was not able to articulate why the submitted information was N/A and what was the observed versus expected readmission ratio. Mercer rates this measure as high confidence given that it was reviewed and certified by the HEDIS vendor; however, Mercer recommends more engagement on [redacted]'s part to use the data in a meaningful way to improve member outcomes.
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.

Appendix A

Annual Compliance Review Agenda

[redacted]
2021 External Quality Review (EQR) Comprehensive Review
August 10, 2021–August 12, 2021

Day 1 — August 10, 2021

TIME	TOPIC
9:45 am–10:00 am	Sign into webinar
10:00 am–10:20 am	Introductions and review of agenda • [redacted] – [redacted] • Mercer – Barbara Anger, Trinity Cleveland, Liz Collins, Jim Cook, Carissa Cramer, Heather Huff, Laurie Klanchar, Laura Pavlecic, Lorene Reagan, Janine Statt, Wendy Woske • [redacted]
10:20 am–11:00 am	Opening presentation by [redacted], followed by questions from [redacted] and Mercer review teams. • *Please see the attached description of what must be covered in the opening presentation.*
11:00 am–11:15 am	**Break**

2021 External Quality Review
[redacted]

[redacted]

Day 1 — August 10, 2021	
11:15 am–12:45 pm	Track team break out meetings • **Track 1: Administration and Organization** — Given the breadth of topics this team may cover; the list of potential topics is provided to ensure the appropriate participants are available – Organizational structure; staffing; contractor responsibilities; guarantees; warranties; certifications; confidentiality; privacy; security; nondiscrimination; enrollment; transfers; disenrollment; marketing; member services; covered services; reporting — Anticipated staff: CEO, COO, Provider Services/Relations Manager, Member Services Manager, Compliance Officer • **Track 2: Utilization Management** — *Please see attached description of what must be covered in this presentation.* — Anticipated staff: CMO, Director of Utilization Management, Utilization Management Supervisors
12:45 pm–1:45 pm	**Lunch**
1:45 pm–3:30 pm	Track team break out meetings • **Track 1: Administration and Organization (continued)** — Anticipated staff: CEO, COO, Provider Services/Relations Manager, Member Services Manager, Compliance Officer • **Track 2: Process for Contractual Reporting and Performance Measure Validation** — Anticipated staff: Director of Quality, Chief Data Analytics Coordinator, selected reporting and analytics staff
3:30 pm–3:45 pm	**Break**
3:45 pm–4:15 pm	[redacted] and Mercer day one debrief (closed session)
4:15 pm–4:45 pm	Day 1 closing session with [redacted]

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2021 External Quality Review [redacted]

[redacted]

Day 2 — August 11, 2021	
TIME	**TOPIC**
9:45 am–10:00 am	Sign into webinar
10:00 am–10:10 am	Opening session
10:10 am–10:50 am	Presentation [redacted] of subcontractual/delegated relationships and responsibilities followed by questions from [redacted] and Mercer review teams. • *Please see attached description of what must be covered in this presentation.*
10:50 am–11:00 am	**Break**
11:00 am–12:30 pm	Track team break out meetings • **Track 1: Pharmacy** – Anticipated staff: Pharmacy Director, Pharmacy Benefit Manager Lead, Subcontractor Oversight • **Track 2: Care Coordination** – *Please see attached description of what must be covered in this presentation.* – All member level – Level 1 Resource Coordination – Level 2 Clinical Care Coordination – Anticipated staff: CMO, Director of Care Coordination, Care Coordinator Supervisors, Training Coordinators • **Track 3: Adult Dental Benefit** – *Please see attached description of what must be covered in this presentation.* – Anticipated staff: Subcontractor Oversight, Dental Benefit Manager (DBM) Representative
12:30 pm–1:15 pm	**Lunch**

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2021 External Quality Review [redacted]

[redacted]

Day 2 — August 11, 2021

1:15 pm–2:45 pm	Track team break out meetings • **Track 1: Care Coordination (continued)** — *Please see attached description of what must be covered in this presentation.* — All member level — Level 1 Resource Coordination — Level 2 Clinical Care Coordination — Anticipated staff: CMO, Director of Care Coordination, Care Coordinator Supervisors, Training Coordinators • **Track 2: Network** — *Please see attached description of what must be covered in this presentation.* — Anticipated staff: Director of Network Development, Network Manager, Credentialing Director, Delegation Oversight Manager, Manager of Provider Information, selected provider relations staff • **Track 3: Quality Management/Quality Improvement** — *Please see attached description of what must be covered in this presentation.* — Anticipated staff: Director of Quality, Quality Manager, selected quality staff
2:45 pm–3:00 pm	**Break**
3:00 pm–3:45pm	[redacted] and Mercer day 2 debrief (closed session)
3:45 pm–4:00 pm	Day 2 closing session with [redacted]

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2021 External Quality Review [redacted]

[redacted]

Day 3 — August 12, 2021	
TIME	**TOPIC**
9:45 am–10:00 am	Sign into webinar
10:00 am–11:45 am	Track team break out meetings • **Track 1: Grievance and Appeal System and File Review** — *Please see attached description of what must be covered in this presentation.* — Anticipated staff: Manager of Grievance and Appeals System, Manager of Member Services, Member Advocates, Manager of Quality Management, selected grievance and appeals staff • **Track 2: DSHP Plus Case Management** — *Please see attached description of what must be covered in this presentation.* — Anticipated staff: CMO, Director of Case Management, Case Management Supervisors, Training Coordinators
11:45 am–12:45 pm	**Lunch**
12:45 pm–2:15 pm	Track team break out meetings • **Track 1: Track 2: DSHP Plus Case Management (continued)** — *Please see attached description of what must be covered in this presentation.* — Anticipated staff: CMO, Director of Case Management, Case Management Supervisors, Training Coordinators • **Track 2: Performance Improvement Projects Validation** — Anticipated staff: Director of Quality, Chief Data Analytics Coordinator, selected reporting and analytics staff, selected quality staff • **Track 3: Provider Services Calls and Credentialing Termination File Review** — Anticipated staff: Director of Network Development, Network Manager, Credentialing Director, Delegation Oversight Manager, Manager of Provider Information, selected provider relations staff

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2021 External Quality Review [redacted]

[redacted]

Day 3 — August 12, 2021	
2:15 pm–2:30 pm	**Break**
2:30 pm–3:30 pm	Outstanding follow up items TBD
3:30 pm–4:15 pm	[redacted] and Mercer day 3 debrief (closed session)
4:15 pm–4:45 pm	EQR 2021 wrap-up with [redacted]

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Appendix D

Sample Comparative Analysis

Mercer

2020 External Quality Review

Medicaid Managed Care Organization Performance Report

State of Delaware
Division of Medicaid & Medical Assistance

April 23, 2021

Services provided by Mercer Health & Benefits LLC
Mercer Proprietary and Confidential

welcome to brighter

Contents

1
Introduction

Purpose of Report

The State of Delaware (Delaware or State) Division of Medicaid & Medical Assistance (DMMA) contracted with Mercer Government Human Services Consulting (Mercer) to conduct an External Quality Review (EQR) of the managed care organizations (MCOs), AmeriHealth Caritas Delaware (ACDE) and Highmark Health Options (HHO), participating in the State of Delaware's Medicaid health care service programs. To complete this review, Mercer applied Federal Regulations for Medicaid Managed Care (FRMMC), the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and State regulations, contractual requirements, each MCO's internal policies and procedures, and State-defined standards communicated to the MCO through its managed care contract and the Medicaid/Children's Health Insurance Program (CHIP)/Diamond State Health Plan (DSHP) Plus Quality Strategy (QS). This report aims to assess MCO performance in accordance with goals identified in DMMA's current QS[1]:

- **Goal 1:** To improve timely access to appropriate care and services for adults and children, with an emphasis on primary and preventive, behavioral healthcare, and to remain in a safe and least-restrictive environment.
- **Goal 2:** To improve quality of care and services provided to Medicaid and CHIP enrollees.
- **Goal 3:** To control the growth of health care expenditures.
- **Goal 4:** To ensure member satisfaction with services.

In addition to evaluating MCO performance with respect to DMMA's QS goals, this report offers a summary of the comprehensive compliance review based on the Centers for Medicare and Medicaid Services (CMS) EQR requirements under 42 CFR 438.358. Based on findings of the descriptive and comparative analyses, Mercer identified MCO strengths and opportunities for improved performance in the delivery of health care services for enrollees in Delaware's managed Medicaid programs.

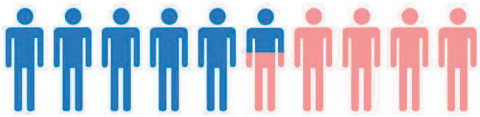
[1] Division of Medicaid & Medical Services. (2018). Delaware Statewide Quality Management Strategy. New Castle: Delaware Department of Health and Social Services.

Population

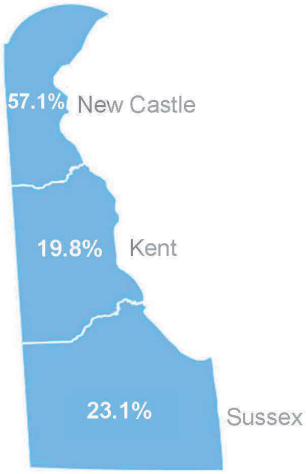
Delaware's Medicaid managed care population accounts for approximately 208,000 eligible individuals. New Castle county has the highest participation at 57.1%, with Sussex county accounting for 23.1% and Kent county accounting for 19.8% of the Medicaid population.

Delaware Medicaid participation reflects a higher percentage of females at 53.8% than males at 46.2%.

Delaware Medicaid Population by Gender*

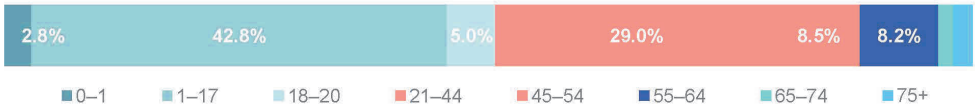


Male: 46% Female: 54%



The largest eligible age groups are children and non-elderly adults making up about 96.3% of the total. Children under 18 account for the highest percentage of members at 45.6% with adults ages 21–44 making up about 29.0% of all participants.

Delaware Medicaid Population by Age Group*



Race and ethnicity breakdowns reveal that the majority of Delaware Medicaid participants are either Caucasian at 56.2% or African American at 40.7%.

**Demographic data shown above is reflective of December 2019 Delaware Medicaid Enterprise System eligibility information, as of July 2020.*

External Quality Review

CMS mandates that each state conduct an EQR for MCOs providing services to Medicaid members. Federal regulations under 42 CFR Part 438, subpart E set forth parameters the State must follow when conducting an EQR of an MCO. The EQR is a systematic analysis and evaluation by a qualified External Quality Review Organization (EQRO). The evaluation requires aggregated information about

the quality, timeliness and access to health care services that an MCO or its contractors provide under contract for Medicaid recipients.

Part of the EQR service includes validation of information furnished to complete the analysis. This includes a review of descriptive information and a review of data and procedures used to determine the extent to which they are accurate, reliable and free from bias, in accord with national standards for data collection and analysis.

Recent changes by CMS to EQR protocols address significant changes in national healthcare policy, which offer new opportunities for measuring and improving quality of health care delivery. This includes changes effected by the CHIPRA Act of 2009, the American Recovery and Reinvestment Act and the Affordable Care Act.

Methodology

Primary data sources for analysis in this report include the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®) and its Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and the 2020 Delaware comprehensive EQR. The performance improvement projects (PIPs) and performance measures (PMs) DMMA selected for validation were based on DMMA's QS goals noted above.

Results for the two Delaware Medicaid MCOs have been de-identified, and respective scores for HEDIS and CAHPS performance measures are reported in comparison to national percentiles from NCQA's Quality Compass.[2] Results are grouped into a rating system of five stars (90th percentile), three stars (50th–89th percentile) or two stars (below 50th percentile). The EQRO evaluated MCO compliance with Medicaid and the CHIP managed care regulations and is presenting them in four domains: enrollee rights and protections, quality assessment and performance improvement, grievances and appeals, certification and program integrity. A similar star scoring approach was used to present results of the validation of PMs and PIPs. See Tables 1–3, below to interpret star ratings throughout the remainder of the report.

Table 1. CAHPS Performance Measure Score Scale

National Percentile Score as Reported by CAHPS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

[2] Quality Compass provides a database of national averages among organizations submitting data to NCQA. Benchmark data comes from accredited and non-accredited organizations and consists of publicly and privately reported performance metrics. Available at: www.qualitycompass.org.

Table 2. HEDIS Performance Measure Score Scale	
National Percentile Score as Reported by HEDIS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

Table 3. EQR Compliance Score Scale	
Compliance Points Earned	EQR Report Score
90% + of possible points	★★★★★
75%–89% of possible points	★★★
< 75% of possible points	★★

Table 4. PM and PIP Validation Score Scale	
PIP/Validation Evaluation	EQR Report Score
Fully compliant	★★★★★
Substantially compliant	★★★
Not compliant	★★

2

Consumer Assessment of Healthcare Providers and Systems

Member Perception of Healthcare Services

One of the goals described in the Delaware Medicaid QS is to "Assure member satisfaction with services." One of the core elements of the DSHP program is to promote member-centricity. Being member-centric, means being focused on providing a positive experience for Medicaid members and designing systems that work for them. Members who exhibit confidence in services delivered to them will engage those services more effectively and frequently, increasing the likelihood of a healthier membership. CAHPS surveys (adult and pediatric) target enrollees' viewpoint and evaluation of their own experiences with health care delivery. The survey covers topics important to enrollees and focuses on aspects of quality they are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The following results and subsequent ratings are based on the CAHPS composite scores developed by combining individual survey questions into broader topics.

A star rating was assigned to each composite measure according to the following scale:

Table 5. CAHPS Performance Measure Score Scale

National Percentile Score as Reported by CAHPS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

Consumer Assessment of Healthcare Providers and Systems Performance Evaluation

A percentile is a statistical measure that indicates performance. Typically, being in a higher percentile indicates better performance. Through its QS, DMMA established a standard of the 75th percentile for CAHPS performance. Once the 75th percentile is achieved, the MCO will work toward achieving the

90th percentile. CAHPS performance varied across domain and by population within each MCO. A side-by-side comparison of both MCOs shows differences in performance as well.

Table 6. CAHPS Performance Measure Ratings — Adult		
Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Rating of personal doctor	★★	★★
Rating of specialist	★★★	★★★
Rating of all health care	★★★	★★★
Rating of health plan	★★★	★★★★★
Getting needed care	★★	★★★★★
Getting care quickly	★★★	★★★★★
How well doctors communicate	★★	★★★

Table 7. CAHPS Performance Measure Ratings — Child		
Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Rating of personal doctor	★★	★★★★★
Rating of specialist	★★	★★★
Rating of all health care	★★	★★★
Rating of health plan	★★	★★★★★
Getting needed care	★★	★★
Getting care quickly	★★★	★★
How well doctors communicate	★★	★★

Overall Member Experience with Care

MCO B had three measures, rating of health plan, getting needed care and getting care quickly that were at or above the 90th percentile. Both MCOs had moderately good ratings for two adult areas: rating of specialist and rating of all health care. Both MCOs have opportunities for improvement in rating of personal doctor; other measure results varied between the MCOs..

Both MCOs have opportunities for improvement in the majority of the child areas. MCO B had strong results on the child measures of rating personal doctor and rating of health plan while MCO A's results were low. MCO A had moderate results on the child measure getting care quickly while MCO B results

were low. Both MCOs had low results in the child area of how well doctors communicate; other measure results varied between the MCOs.

MCO A performed moderately well on the adult and low on the child CAHPS survey. MCO A performed at or above the benchmark for the 50th percentile for CAHPS metrics nationwide for adult measures with the exceptions of the rating of personal doctor, getting needed care, and how well doctors communicate that all scored lower than the 50th national percentile. Plan members who completed the CAHPS survey scored three adult metrics as moderate (rating of specialist, rating of all health care, rating of health plan and getting care quickly). While there were positive results within the adult CAHPS survey, the child survey results for MCO A highlight opportunities for improvement. Plan members who completed the CAHPS survey scored one child metric as moderate (getting care quickly) and the rest of the child metrics as low (rating of personal doctor, rating of specialist, rating of all health care, rating of health plan, getting needed care and how well doctors communicate).

Members rated MCO B's performance at or above the 90th percentile benchmark for three of the adult measures (rating of health plan, getting needed care, and getting care quickly) as well as two of the child measures (rating of personal doctor and rating of health plan). Areas in need of improvement for MCO B are the adult measure rating of personal doctor as well as the child measures for getting needed care, getting care quickly, and how well doctors communicate (lower than the 50th percentile). All other metrics reveal moderate performance between the 50th and 90th percentiles for MCO B.

Comparing MCO A to MCO B suggests opportunities for improvement at both MCOs. Primary concerns for MCO A revealed by this year's reporting include the adult and child metrics for rating of personal doctors, getting needed care and how well doctors communicate. Primary concerns for MCO B include the adult metric for rating of personal doctors and child metrics for getting needed care, getting care quickly and how well doctors communicate.

3

Healthcare Effectiveness Data and Information Set Results

This section provides an overview of two HEDIS domains of care: Access to Care and Quality of Care. Analysis using HEDIS for performance evaluation is industry standard for external reporting in the managed care industry. HEDIS is developed and maintained by NCQA. Data used for calculating HEDIS results include information from medical charts and provider claims (i.e., encounter data from electronic health records, claims data from billing systems, etc.) within Delaware's Medicaid managed care network. NCQA originally designed HEDIS to allow consumers to compare health plan performance against the quality of other health plans, as well as national and regional benchmarks. A star rating was assigned as follows for each composite measure.

Table 8. HEDIS Performance Measure Score Scale

National Percentile Score as Reported by HEDIS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

Evaluation of Effectiveness and Access to Health Care

The Delaware QS prioritizes improvement of timely access to appropriate care and services for adults and children, with an emphasis on primary preventive care and remaining in a safe and least-restrictive environment. Providing timely access to preventive and primary care services promotes the goal of a comprehensive health care delivery system for Delaware Medicaid.

Timely Access to Primary and Preventive Services

Medicaid enrollees who utilize primary and preventive services have been found to be better equipped to manage acute and chronic medical conditions, versus those who do not have access to these services. Patients with adequate access to primary care are more likely to have preventive care, as well as consistent care for chronic conditions. Both have been shown to reduce unnecessary emergency department visits and inpatient hospital admissions.

MCO B was at or above the 50th percentile in six of the seven timely access to primary and preventive services measures, with the exception of adults ages 20 years–44 years, which was below the 50th percentile. MCO A was at or above the 50th percentile on only one of the seven timely access to primary and preventive services measures; the MCO was below the 50th percentile in all of the child and adult access to preventive services with the exception of adults ages 65+ years, which was above the 50th percentile.

Table 9. Timely Access to Primary and Preventive Services

HEDIS Performance Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Children's access to primary care physician (PCP) (Ages 12 months–24 months)	★★	★★★
Children's access to PCP (Ages 25 months–6 years)	★★	★★★
Children's access to PCP (Ages 7 years–11 years)	★★	★★★
Adolescent's access to PCP (Ages 12 years–19 years)	★★	★★★
Adult's access to preventive/ambulatory health services (Ages 20 years–44 years)	★★	★★
Adult's access to preventive/ambulatory health services (Ages 45 years–64 years)	★★	★★★
Adult's access to preventive/ambulatory health services (Ages 65+ years)	★★★	★★★

NR: A designation given by NCQA to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.

Access to Maternal and Pregnancy Services

Early and consistent access to quality prenatal care services can improve chances of delivering healthy babies and decreasing maternal and infant deaths. Providing access to comprehensive maternal and prenatal services impacts MCO service delivery significantly, and constitutes effective means of preventing lifelong disability via healthy deliveries. MCO A and MCO B both performed below the 50th percentile for access to maternal and pregnancy services during 2020.

Table 10. Access to Maternal and Pregnancy Services		
HEDIS Performance Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Prenatal and postpartum care — timeliness of prenatal care	★★	★★
Prenatal and postpartum care — postpartum care	★★	★★

Overall Access Performance

HEDIS results provide a litmus test for evaluating patient access to care. The comparisons of reportable-HEDIS data between MCOs and against the national benchmarks, above, indicate both MCOs need to focus quality improvement strategies for accessing preventive and maternity care.

Evaluation of Quality of Care

The Delaware Medicaid QS includes goals of improving quality of care and services provided to DSHP, DSHP Plus and CHIP members. Quality-related PMs describe attributes of health services provided to members. These PMs provide an overview of the effectiveness of a health care delivery system by looking at service utilization, patients' health outcomes and comprehensiveness of disease management services for common causes of morbidity and mortality.

Evaluation of Neonatal Services

Effective preventive care begins early in life. Healthier children will be more likely to remain healthier as adults. High-quality health care in early stages of life promotes a healthier membership pool. As shown in the following table, MCO A performed below the 50th percentile in all measures for quality of early life services, while MCO B performed above the 50th percentile.

Table 11. Quality of Early Life Services		
HEDIS Performance Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Childhood immunization status (Combination 2)	★★	★★★
Sufficient (6+) well-child visits in first 15 months of life	★★	★★★
Well-child visits in years 3–6	★★	★★★

Evaluation of Early Detection Services

Routine screenings and early detection services allow providers to identify and address health concerns at an early stage, often preventing costly and invasive interventions associated with later

detection. As shown below, MCO A performed below the 50th percentile for cervical cancer screening, while MCO B performed below the 50th percentile for both breast cancer and cervical cancer screening.

Table 12. Early Detection Service Quality		
HEDIS Performance Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Breast cancer screenings	NR	★★
Cervical cancer screenings	★★	★★

NR: A designation given by NCQA to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.

Quality of Diabetes Management Services

Diabetes mellitus has a strong association with morbidity and mortality in the United States. Often associated with inadequate diabetes management, comorbidities such as hypercholesterolemia (high cholesterol), hypertension (high blood pressure), and other chronic conditions merit attention. Comprehensive care for this disease includes a variety of monitoring services. As shown below, both MCOs' HEDIS scores indicate the need for improvement in diabetes care.

Table 13. Quality of Diabetes Management		
HEDIS Performance Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Comprehensive diabetes care — HbA1c testing	★★	★★
Comprehensive diabetes care — dilated retinal eye exam	★★	★★

Weight and Nutrition Management Quality

Also associated with morbidity and mortality in the United States is obesity and its related health conditions. Expenditures attributed to these conditions are also on the rise. When initiated early in life, proper nutrition, physical activity, weight assessment and control effectively prevent obesity and the associated disease burden. Nutrition counseling is an important means of educating individuals in order to help them lead healthier, more productive lives. MCO A is at or above the 50th percentile for counseling for nutrition and physical activity among children and below the 50th percentile for adult body mass index assessment. MCO B is below the 50th percentile for all of the clinical quality of weight and nutrition management measures.

Table 14. Clinical Quality of Weight and Nutrition Management		
HEDIS Performance Measure Description	2020 MCO A Ratings	2020 MCO B Ratings
Adult body mass index assessment	★★	★★

Table 14. Clinical Quality of Weight and Nutrition Management		
Counseling for nutrition	★★★	★★
Counseling for physical activity	★★★	★★

NR: A designation given by NCQA to indicate either the MCO chose not to report the measure or the measure received an NR designation during a NCQA HEDIS Compliance Audit.

Overall Quality Performance

Strengths and Opportunities

MCO A scored low to moderate for overall performance on measures pertaining to timely access to primary and preventive services as well as the quality of early life services. MCO A's performance was lower than the 50th percentile on measures pertaining to access to maternal and pregnancy services. MCO A is at or above the 50th percentile for counseling for nutrition and physical activity among children and below the 50th percentile for adult body mass index assessment. These preventive services as well as services to the young and vulnerable population are keys to improving the health outcomes of the Delaware Medicaid population.

MCO B reached or was above the 50th percentile for all but one of the timely access to primary and preventive services as well as the quality of early life services. MCO B's performance was lower than the 50th percentile on measures pertaining to access to maternal and pregnancy services. Both MCOs have opportunities for significant improvement with early detection and service intervention as well as with diabetes management. This topic has been an ongoing theme targeted by DMMA's Quality Improvement Initiative task force and MCO quality committees. Significantly improved performance in these areas could improve the quality of life, decrease illness of Delaware Medicaid enrollees.

4

External Quality Review: Compliance

Compliance Scoring

As required by CMS under federal regulation, Mercer, acting as the EQRO, completed a comprehensive compliance review of the MCOs using the CMS protocol "Assessment of Compliance with Medicaid Managed Care Regulations." The review has been grouped into the compliance areas below:

- Enrollee rights and protections
- Quality assessment and performance improvement
- Grievances and appeals
- Certifications and program integrity

The EQRO compliance evaluation assigns the MCO a score for each metric that makes up these four review areas. The assessment of "Met", "Substantially Met", "Partially Met", "Minimally Met" and "Not Met" is given a score, and an equal weighting was assigned to each of the four standards. Regulation mandates MCOs develop a required corrective action plan (CAP) for all metrics resulting in a "Substantially Met", "Partially Met", "Minimally Met" or "Not Met" rating. All CAPs are reviewed and approved for implementation by DMMA prior to integration. A star rating was assigned to the MCOs based on their overall compliance score according to the rating scale below.

Table 15. EQR Compliance Score Scale

Compliance Points Earned	EQR Report Score
90% + of possible points	★★★★★
75%–89% of possible points	★★★
<75% of possible points	★★

Compliance Evaluation

MCO A scored above 90% on all four content areas of the compliance review. MCO B scored above 90% in the areas of enrollee rights and protections, grievances and appeals and certifications and program integrity. The area in need of the most improvement for MCO B is quality assessment and performance improvement. (Table 16).

Table 16. 2020 MCO Overall Compliance Ratings

	MCO A			MCO B		
Content Area	Possible Points	Points Scored	Percent	Possible Points	Points Scored	Percent
Enrollee Rights and Protections	25	25.00	100.0%	25	25.00	100.0%
Quality Assessment and Performance Improvement	25	24.74	98.9%	25	22.19	88.8%
Grievances and Appeals	25	25.00	100.0%	25	24.73	98.9%
Certifications and Program Integrity	25	25.00	100.0%	25	25.00	100.0%
Total	100	99.74	99.7%	100	96.92	96.9%
Total Compliance Rating	★★★★★			★★★★★		

Overall Compliance Performance

Strengths and Opportunities

Both of Delaware's Medicaid MCOs performed well overall in 2020, scoring in the highest compliance-rating tier. While MCO A attained greater than 90% of possible points in all four areas, MCO B earned greater than 90% of the points possible in three areas: Enrollee Rights and Protections, Grievances and Appeals and Certifications and Program Integrity. These results indicate that both MCOs are compliant with the majority of federal regulations and State contract expectations.

Findings of the compliance review indicate room for improvement at MCO B for Quality Assessment and Performance Improvement (QAPI) measures. Identifying which parts of a healthcare system need attention requires a strong QAPI framework — a key to quality improvement throughout complex healthcare delivery systems.

While both MCOs performed well, even those areas that achieved more than 90% compliance may still have items that require a CAP. The State reviews, approves all CAPs, and monitors those action plans to ensure that all identified issues are corrected.

5

Performance Measurement

Validation of Performance Measures

Performance measurement uses robust tools and methodologies to collect information about large complex health care delivery systems. The objective of the PM validation in the compliance process is to validate accuracy of Medicaid, CHIP and DSHP/DSHP Plus PMs reported by the MCOs to DMMA. The review process includes application of the CMS protocol entitled "Validating Performance Measures," which is aimed at assessing compliance with specifications for each PM.

The measures reviewed for 2020 were mandated by the State and used technical specifications developed as part of the State's Quality Care Management Monitoring Report and CMS Adult and Pediatric Core Measure reporting. To validate the PMs, Mercer referenced the annual compliance review and Information Systems Capabilities Assessment Request for Information responses with supporting documentation. During onsite meetings, Mercer led discussions about data management processes, report generation, data validation, and data submission. After all audit elements were assessed, a validation finding for each measure was determined based on the magnitude of errors detected in the review. The following table summarizes the scale used to evaluate performance measure compliance.

Table 17. Performance Measure Validation Scoring Scale

Validation Evaluation	EQR Report Score
Fully compliant	★★★★★
Substantially compliant	★★★
Not compliant	★★

The following table shows a breakdown of PMs that were validated for 2020:

Table 18. Performance Measures Validated

Measure Description	Reporting Frequency	Reporting Format
Chlamydia Screening in Women	Annual	CMS Core Measure
Prenatal and postpartum care (timeliness of prenatal care)	Annual	CMS Core Measure
HIV Viral Load Suppression	Annual	CMS Core Measure

Table 18. Performance Measures Validated		
Measure Description	Reporting Frequency	Reporting Format
Developmental Screening in the First 3 Years of Life	Annual	CMS Core Measure
Access — timely appointments Maternity 3rd trimester	Quarterly	Quality and Care Management Measurement Reporting Templates (QCMMR)
Case Management Reassessments	Monthly	QCMMR

Validation of Performance Measure Assessment

The validation process reveals that both MCO A's and MCO B's reported performance measurement was fully compliant. The following table shows a side-by-side comparison of the results for both MCOs:

Table 19. Performance Measure Validation Ratings		
Measure Description	MCO A	MCO B
Chlamydia Screening in Women	★★★★★	★★★★★
Prenatal and postpartum care (timeliness of prenatal care)	★★★★★	★★★★★
HIV Viral Load Suppression	★★★★★	★★★★★
Developmental Screening in the First 3 Years of Life	★★★★★	★★★★★
Access — timely appointments Maternity 3rd trimester	★★★	★★★★★
Case Management Reassessments	★★	★★★★★

6

Performance Improvement Projects

Validation of Performance Improvement Projects

The CMS regulations require each state MCO to establish PIPs as part of their quality assurance program. These PIPs, which are validated using the CMS Protocol, are intended to evaluate and improve upon the processes and outcomes associated with specified health care targets. DMMA has mandated that each MCO conduct three PIPs. The State selected all three PIPs for independent validation by the EQRO during the 2020 compliance review cycle. The first PIP was a State-mandated study topic and study question. The second PIP was a State-mandated topic, but MCO-developed study questions. The third required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA as relevant to the needs of Delaware's Medicaid and CHIP populations. Table 20 below includes the study topics validated and confidence in the reported results.

Table 20. PIP Validation Score

Measure Description	MCO A Confidence in Reported Results	MCO B Confidence in Reported Results
Oral health for DSHP Plus long term services and supports membership	Moderate	Low
ADHD clinical practice guidelines, medication and therapy	High	
Benzodiazepines and Opioids concomitant use	High	
Physical Health and Behavioral Health Care Coordination		Moderate
Pediatric Lead Screening		Moderate

Assessment for MCO A

Throughout 2018, there was a significant investment by DMMA in technical assistance to MCO A to ensure there was a solid foundation for assessment of the baseline year of the PIPs at the time of the 2019 EQR. This foundation is critical to ensure rapid cycle analysis can be performed during the initial year of interventions and barrier analysis to drive improvement from the baseline. In 2019, the PIPs

were clearly written, detailed and aligned with identified population health concerns. Given the technical assistance sessions and the desk review assessment of compliance with expectations, the majority of the onsite discussion was focused on the initial interventions developed, the barrier analysis completed to date and baseline results. The EQR evaluation demonstrated a high degree of confidence in the foundational steps.

DMMA has mandated that each MCO conduct a minimum of five PIPs covering specific topics; MCO A has not met the minimum requirements for PIPs based on the Delaware Quality Strategy as of the 2020 EQR. As an essential component of a MCO's quality program to identify, assess, and monitor improvement in processes or outcomes of care, MCO A should assess opportunities across the spectrum of the organization and business units to identify and implement PIPs.

Assessment for MCO B

Throughout 2015, there was a significant investment by DMMA in technical assistance to MCO B to ensure there was a solid foundation for assessment of the baseline year of the PIPs at the time of the 2016 EQR. In 2016, the EQR reported that the PIPs were clearly written, detailed and aligned with identified population health concerns. At that time the EQR evaluation demonstrated a high degree of confidence in the foundational steps. In 2017, the EQR evaluation indicated only moderate confidence in the PIPs. These results were based on challenges with data collection, system changes that impeded accurate reporting of data, as well as limited barrier analysis, delayed implementation of interventions and lack of consistent rapid cycle analysis. In 2018 the EQRO reported there was not the significant improvement the EQRO anticipated in process and results for the PIPs.

In 2019, there was some improvement in outcomes of the PIPs in comparison to previous years; however, documentation of the PIP processes, limited statistical analysis, staffing issues including a lack of stability and continuity in the QM/QI department, results in only moderate confidence in the reported results and the sustainability of improvement for two of the three PIPs validated.

The QM/QI department of MCO B has faced significant challenges throughout the past four years. At the time of the review in July 2019 into the first quarter of 2020 the QM/QI department did not have a permanent Director and the Quality Manager position as well as the four Clinical Quality Management Analyst positions were staffed with temporary staff. The lack of leadership and direction in the QM/QI department lead to PIPs that lacked a strong design, did not have lead and lag measures that were well-defined, interventions that were not highly effective and results that did not demonstrate improvement. Throughout 2020 two PIP topics were retired, one PIP topic was redesigned and one new PIP was implemented

Any issues identified with the PIP documentation or the MCOs ability to demonstrate continual improvement efforts require a CAP. The State reviews and approves all CAPs and monitors those actions plans to ensure that all identified issues are corrected. As a result, MCO's must submit quarterly progress updates to the State outlining their movement towards achieving desired outcomes.

7

Conclusion

The summary results of the EQR as presented above indicate that the MCOs in Delaware are deficient in meeting expectations to improve timely access to care, to improve the quality of care, to control the growth of healthcare expenditures while ensuring members are satisfied with services as outlined in the QS.

The MCOs have shown strong performance in compliance with federal regulations. However, as evidenced by the HEDIS results, both MCOs have room for improvement in timely access to primary and preventive services, access to maternal and pregnancy services, quality of early life and early detection services, quality of weight and nutrition management and diabetes management.

While members for one MCO shared a relatively high level of satisfaction with five of the 14 CAHPS adult or child measures, they have opportunity for improvement in the remaining nine measures. The second MCO has significant opportunity to improve member satisfaction in all CAHPS adult and child measures.

DMMA will continue working collaboratively with the MCOs as they implement activities towards continuous quality improvement.

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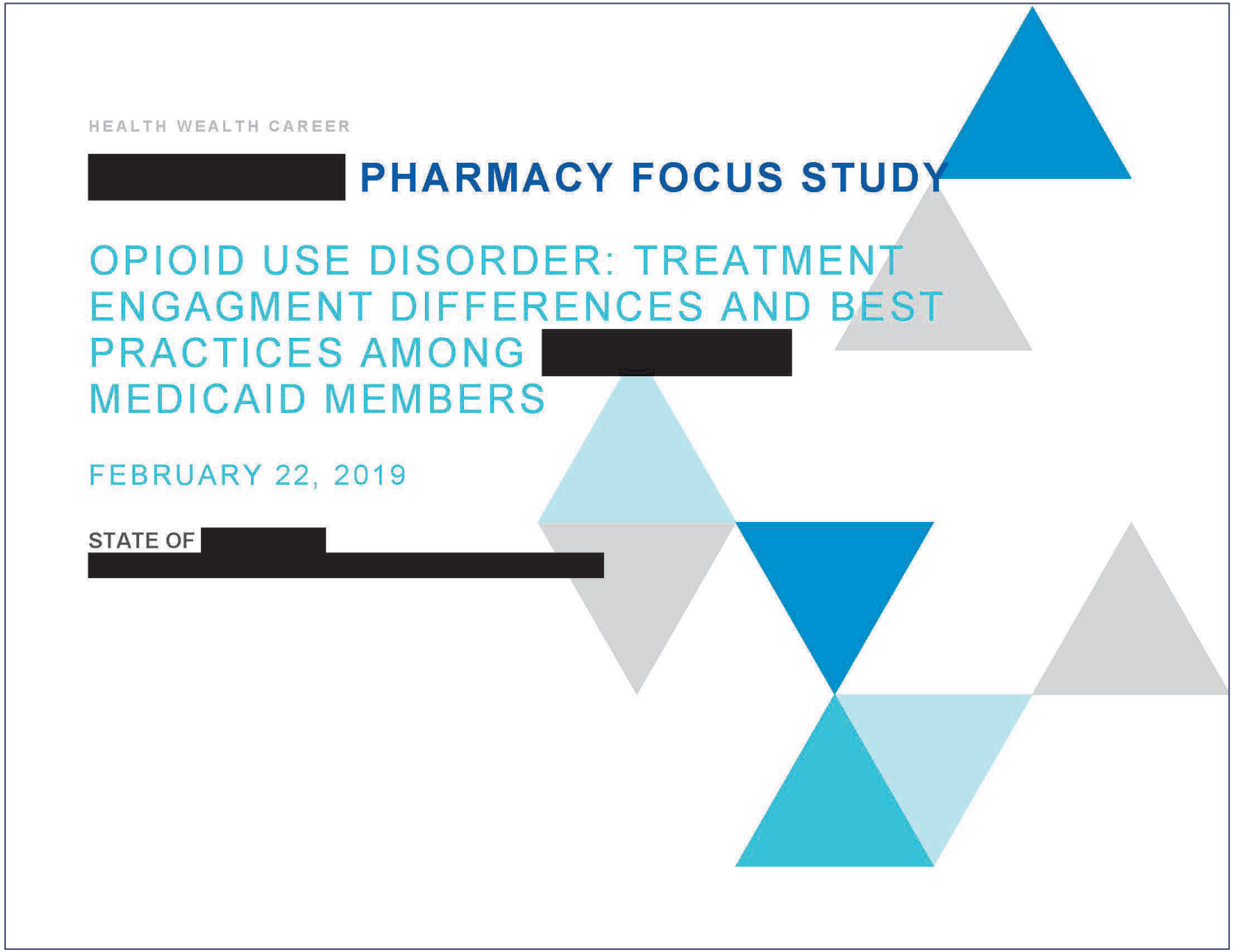
Appendix E
Rx Focus Study


HEALTH WEALTH CAREER
[redacted] PHARMACY FOCUS STUDY
OPIOID USE DISORDER: TREATMENT ENGAGMENT DIFFERENCES AND BEST PRACTICES AMONG [redacted] MEDICAID MEMBERS
FEBRUARY 22, 2019
STATE OF [redacted]

CONTENTS

1
EXECUTIVE SUMMARY

[redacted] asked Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to conduct a pharmacy focus study as one of the 2018 External Quality Review optional activities.

The purpose of the pharmacy focus study was to identify differences in treatment engagement levels for Medicaid members prescribed buprenorphine for an opioid use disorder (OUD) and potential, underlying reasons for any noted differences. Buprenorphine is a prescription drug used to treat OUDs. While medication is an important part of successfully treating certain addictions, including OUD, research has shown Medicated Assisted Treatment (MAT) is most beneficial when used in combination with counseling, other behavioral therapies, peer support, and/or self-help groups.

STUDY QUESTIONS

The study questions addressed in this report focused on the members who demonstrated active and ongoing engagement in treatment. Medical claims for these members were analyzed to assess commonalities and outcomes. Mercer explored the following questions:

1. Do members with more treatment engagement visits for OUD have better outcomes than those with only two, or another limited number of, visits?
2. Do members with more treatment engagement visits for OUD have particular providers, clinics, and/or prescribers in common?
3. Do members with more treatment engagement visits for OUD have similar buprenorphine claim types (NDC claims filled at a retail pharmacy vs. Healthcare Common Procedure Coding System (HCPCS) claims from a visit to an Opioid Treatment Program (OTP))?
4. Are there additional common characteristics to be noted for those members who remain engaged in treatment for OUD?

STUDY METHODOLOGY

To help understand the differences in engagement levels for members prescribed buprenorphine for OUD, Mercer searched [redacted] National Council for Prescription Drug Programs (NCPDP) and HCPCS pharmacy data from 2017 to find encounters for buprenorphine. This search resulted in a dataset of 3,130 members who were prescribed buprenorphine. Mercer studied medical encounter data for these members to analyze the differences in engagement levels and attempt to find commonalities among those members with higher engagement rates when compared to those who were less engaged in ongoing treatment.

KEY FINDINGS

Study Question 1

Do members with more treatment engagement visits for OUD have better outcomes than those with only two, or another limited number of, visits?

Finding 1

Based on Mercer's review of the medical encounter data of engagement-qualifying visits, a stark difference exists in provider choice and procedure codes between those members with higher engagement and those with lower engagement. Members in the higher engagement groups were more likely to receive treatment with mental health professionals such as psychologists, and their visits were overwhelmingly coded as visits for psychotherapy and addiction treatment. In contrast, members showing lower engagement levels more often received treatment from internal medicine or family practice providers, and the vast majority of their visits were coded simply as office visits.

Mercer believes the higher engagement members may benefit from the treatment they receive from specialized providers; in some cases, this may lead to better overall outcomes and extended engagement in treatment.

Study Question 2

Do members with more treatment engagement visits for OUD have particular providers, clinics, and/or prescribers in common?

Finding 2

Members in the higher engagement groups do have common providers. Examples of providers most commonly visited by these members include: [redacted]. In general, these providers are not as commonly visited by members showing lower engagement.

Interestingly, these differences are less evident when researching members' buprenorphine prescribers. Members in both the higher engagement and lower engagement groups show very similar top-prescriber lists, including some concerning and/or questionable prescriber choices, detailed later in this report. This indicates that even members who are more engaged in treatment with quality mental health providers are going elsewhere for their buprenorphine prescription.

Mercer believes there are multiple possibilities to explain this phenomenon, and further research and interviews with providers may be necessary to determine the root cause. Possible reasons a member who is highly-engaged in treatment but would visit a different prescriber may include:

- The specialized provider may be reluctant to prescribe buprenorphine and is referring members elsewhere for their medication. If that is the case, these providers may benefit from additional training, tools and other resources to overcome this reluctance. For example, some states establish a hub-and-spoke structure to provide additional networking support and consultation for office-based opioid treatment (OBOT) providers. Alternatively, an enhanced payment may effectively incentivize these providers to begin prescribing buprenorphine at their clinic site. It is also noteworthy that, as noted below, the higher engagement groups receive a higher percentage of their buprenorphine units through HCPCS billing, suggesting they are making more frequent (possibly daily) in-person visits to an Opioid Treatment Program (OTP). Interestingly, physicians working in OTP settings are not required to complete the 8 hours of training and to obtain the DATA 2000 waiver in order to prescribe buprenorphine, so it is possible they are more reluctant to prescribe this medication.
- The specialized provider has the ability to provide the prescription and is willing to serve in this role, but the member has chosen to obtain buprenorphine from a different provider. If this is the case, these specialized providers and members may benefit from having

materials available that articulate pros and cons associated with having prescribing clinicians not associated with the provider where the member is receiving the other supportive behavioral services.

- The specialized provider has buprenorphine waivered clinicians, but these clinicians have reached their authorized patient capacity and have not requested, or are not eligible to request, an increase in patient limit at the current time. If that is the case, an enhanced payment may effectively incentivize these providers to hire additional waivered clinicians or pursue an increase in patient limit (if eligible).

Study Question 3

Do members with more treatment engagement visits for OUD have similar buprenorphine claim types (NDC claims filled at a retail pharmacy vs. HCPCS claims from a visit to an OTP?

Finding 3

Mercer found members in the higher engagement groups receive a higher percentage of their buprenorphine units through HCPCS billing. This generally suggests more frequent (possibly daily) in-person visits to an OTP than units billed through NDCs at a retail pharmacy. Not all of these HCPCS dispenses were single-unit, but for those higher engagement members who received more than 1 HCPCS unit at a visit, their quantities ranged from 1 to 20 units. The members involved received varying amounts at frequent, recurring intervals suggesting multiple monthly visits.

Members in the highest engagement group received 22% of their buprenorphine units via HCPCS, while members in the lowest engagement group received 3% of their units via HCPCS. Mercer believes the frequent-visit nature of HCPCS dispensing leads to better long-term engagement and success.

Study Question 4

Are there additional common characteristics to be noted for those members who remain engaged in treatment for OUD?

Finding 4

Members in the lower engagement group show three of their top 10 primary diagnosis codes and two of their top 10 non-primary diagnosis codes related to back pain, headache pain, and gastritis pain. Members in the higher engagement group do not have any pain-related codes

in their top 10 lists. This suggests lower engagement members are still suffering from pain issues, and thus are less likely to stay engaged in treatment and more likely to return to opioid use for pain mitigation. Assuming this comorbid pain does impact ongoing engagement in SUD treatment, this reinforces the importance of coordinated care and pain management interventions. Conversely, perhaps those members with higher engagement no longer have (or never had) pain issues interfering with their treatment goals.

KEY RECOMMENDATIONS

- Mercer recommends collaboration and further study with the providers shown to be most successful in retaining members in ongoing treatment to determine if the members under their care are truly successful in treatment. If so, perhaps there are best practices they can identify and share with their colleagues. A survey with members who have demonstrated higher/stronger engagement with these providers could further inform strategies and factors that have contributed to their successful engagement.

- Mercer recommends and encourages the national efforts to expand access to MAT by leveraging physicians, nurse practitioners, and physician assistants in a variety of practice environments, including primary care. While these provider types can, and should, be part of the solution in addressing the opioid epidemic and in treating OUD, non-behavioral health providers could benefit from additional educational opportunities addressing engagement and retention best practices.

- Mercer recommends leveraging claims and utilization data to identify clinicians whose opioid-prescribing patterns go against clinical guidelines. Outreach to these clinicians can provide feedback to assist in creating more effective treatment options for their patients.

- Mercer recommends more intensive care coordination and intervention for members who have proven to be more difficult to engage and retain in treatment; these members may benefit from referral to a behavioral health provider.

- Mercer recommends further study, research, and collaboration with providers who dispense buprenorphine in smaller quantities though frequent in-person visits. These providers may have valuable insight into how and why they use this dispensing method rather than sending members to a retail pharmacy, and perhaps will be able to further support or refute the higher engagement indicated in this study.

- Mercer recommends [redacted] the MCOs, and other stakeholders continue to support efforts to broaden access to buprenorphine prescriptions and remove prescriber capacity limits to avoid forcing members to find a prescriber outside of their behavioral health facility.

2
INTRODUCTION

The mission of [redacted] is to "improve the quality of life for [redacted] citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations." The mission of the [redacted] is to "improve health outcomes by ensuring that the highest quality medical services are provided to the vulnerable populations of [redacted] in the most cost effective manner." In pursuit of these complementary missions, [redacted] asked Mercer, which has served as the External Quality Review Organization (EQRO) for [redacted] since 2006, to conduct a pharmacy focus study as one of the 2018 External Quality Review optional activities.

The purpose of the pharmacy focus study was to identify differences in treatment engagement levels among [redacted] Medicaid members prescribed buprenorphine. Buprenorphine is a prescription medication used in MAT to treat opioid dependence and is included as a component of a complete treatment program that includes counseling and behavioral therapy.

The Substance Abuse and Mental Health Services Administration's 2017 National Survey on Drug Use and Health report[1] indicated approximately 11.4 million Americans aged 12 or older misused opioids in 2017, including 11.1 million pain reliever misusers and 886,000 heroin users. The Centers for Disease Control and Prevention estimated there were more than 52,000 overdose deaths in 2016 and expected that number to rise 38% to over 71,000 in 2017[2]. Opioids are the drivers for these statistics in overdose deaths, including both legally-prescribed opioid narcotic analgesics as well as illegal drugs like heroin or street fentanyl. The National Institute on Drug Abuse's recent statistics suggest every day, opioid overdoses kill more than 115 Americans[3]. The economic impact of the crisis is estimated to be

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[1] https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf; accessed January 9, 2019.

[2] http://www.cnn.com/2017/09/08/health/heroin-deaths-samhsa-report/index.html.

[3] https://www.drugabuse.gov/drugs-abuse/opioids/opioid-crisis#one.

$78.5 billion a year. Given that [redacted] experienced a 35%[4] increase in overdose-related deaths between 2015 and 2016, it is important to evaluate the level of treatment engagement for those members using opioid-use disorder medications to attempt to assess best practices and common characteristics observed for those members with higher levels of engagement in treatment.

STUDY QUESTIONS

The specific study questions developed for this study were:

1. Do members with more treatment engagement visits for OUD have better outcomes than those with only two, or another limited number of, visits?
2. Do members with more treatment engagement visits for OUD have particular providers, clinics, and/or prescribers in common?
3. Do members with more treatment engagement visits for OUD have similar buprenorphine claim types (NDC claims filled at a retail pharmacy vs. HCPCS claims from a visit to an Opioid Treatment Program (OTP))?
4. Are there additional common characteristics to be noted for those members who remain engaged in treatment for OUD?

BACKGROUND INFORMATION

[redacted] Medicaid membership consists of over [redacted] members who are primarily enrolled in a Managed Care Organization (MCO) model authorized under a Section 1115 demonstration. [redacted] MCOs contractually agreed to the "provision of high quality, cost-effective and integrated managed care services."[5] Of particular interest to [redacted] pharmacy staff is that the MCOs effectively manage the pharmacy benefit by providing appropriate member access to medications while ensuring their safe and effective use. When it comes to treatment for OUD, best practice includes MAT (the use of buprenorphine, methadone, or naltrexone, ideally in combination with counseling), other behavioral therapies, peer support, and/or self-help groups. This study specifically looked at the use of buprenorphine.

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[4] [redacted]

Buprenorphine

The United States Department of Health and Human Services references, as its top priority, access to treatment and recovery services to help address the current opioid crisis. Buprenorphine is considered one of the essential medicines by the World Health Organization for treatment of OUD and is an important tool in addressing the opioid crisis. However, as noted above, it is also important to understand whether those members prescribed buprenorphine are also engaged in other supportive treatment services.

Buprenorphine has been shown in clinical studies to effectively treat OUD when used in combination with behavioral therapies[6] [7]. Buprenorphine exerts its effects on opioid receptors in the brain allowing individuals addicted to opiates to avoid the intense cravings and withdrawal symptoms that make quitting opiates so difficult. At the same time, buprenorphine does not create nearly the same level of euphoria as drugs like heroin. Even if someone abuses this substance by taking more than directed, there's a point at which the effect levels off and, no matter how much is taken, the individual will not experience any additional pleasurable effects. Because buprenorphine is a partial agonist, it can help suppress withdrawal symptoms while also producing weaker pleasurable effects and respiratory depression compared to other opioids (e.g., heroin, hydrocodone, methadone). These factors contribute to a wider margin of safety.

Since the introduction of buprenorphine its prescribing has been regulated by the Drug Addiction Treatment Act of 2000 (DATA 2000). This legislation limits the number of patients a given prescriber can treat concurrently. Depending on licensure and experience, patient caps can vary from 30 to 100 to 275[8]. While patient caps have been amended since their introduction, and new provider types allowed, restrictions still exist for the use of buprenorphine in treating OUD. These restrictions are aimed to prevent diversion and potential abuse given its partial agonist qualities as noted above. Critics, however, complain it is inconsistent to allow prescribing clinicians to prescribe opioids to treat pain

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[6] http://www.aafp.org/afp/2006/0501/p1573.html.

[77] https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/020732s006s007lbl.pdf.

[8] https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/increase-patient-limits

(including methadone and buprenorphine) to an unlimited number of patients, which may lead to addiction, and then restrict how many patients prescribers can prescribe buprenorphine to in order to treat the addiction[9].

[9] https://www.naabt.org/reasons.cfm

3
METHODOLOGY

OVERVIEW

To help understand the differences in treatment engagement levels in members using buprenorphine, the study design was created to include both NCPDP pharmacy claims encounter data and medical claims encounter data from Calendar Year (CY) 2017. The study design did not include any medical record review or other type of data sampling.

Mercer searched [redacted] universe of NCPDP and HCPCS pharmacy encounter data to identify all members who filled a prescription or were administered buprenorphine, resulting in a list of 3,130 members. Using this member list, Mercer searched medical claims data for visits qualifying as an engagement visit per the 2018 Healthcare Effectiveness Data and Information Set (HEDIS) Alcohol and Other Drug (AOD) specifications[10]. Engagement claims were found for 96% (n=2,993) of the original 3,130 members. This set of medical data, consisting of 53,695 total medical claims, was used to further analyze member demographics, treatment engagement levels, services provided, and involved providers.

In order to stratify the 2,993 members into groups reflecting higher/stronger levels of engagement versus lower/weaker levels of engagement, Mercer divided the data into quartiles, based on a range of visits by member. The visit counts by member ranged from a minimum of 1 visit (84 members) to a maximum of 104 visits (1 member). Mercer evenly portioned quartiles of 26 visits per quartile as noted in Table 1 below and identified the number of unique members fitting within each quartile.

[10] https://www.ncqa.org/hedis-2018-measures/

Table 1: Member engagement visit counts by Quartile:

QUARTILE	1	2	3	4	TOTAL
Number of Visits	1-26	27-52	53-78	79-104	
Number of Members	2,352	561	67	13	2,993
Percent of Total	78.6%	18.7%	2.2%	0.4%	100%

Mercer studied characteristics of members demonstrating higher/stronger engagement by analyzing members with visit counts in quartile 4 (13 members) and quartiles 3 & 4 combined (80 members). For comparison, Mercer also studied a subset of quartile 1 members to better understand those with the lowest/weakest engagement, defined here as five engagement visits or fewer (498 members).

CREATION OF STUDY QUESTIONS

Study questions were developed in a series of collaborative meetings with staff from Mercer and [redacted]. The initial impetus for the study was the EQRO 2017 Pharmacy Focus Study, "Treatment Engagement Differences Among Members Prescribed Buprenorphine", which explored the buprenorphine prescribing limit that is specified in [redacted] buprenorphine prior authorization criteria, and the differences in prescribing patterns between the MCOs in [redacted] program. The 2017 study grew into a larger effort to assess the overall healthcare of the members prescribed buprenorphine and to determine whether the strategies employed by the MCOs are succeeding in fulfilling [redacted] and [redacted] mission statements. For this study, [redacted] was interested in attempting to better understand what may be impacting successful retention in OUD treatment.

To identify qualifying treatment engagement visits, Mercer leveraged the HEDIS standards for initiation and engagement of AOD members receiving buprenorphine.

STUDY POPULATION

The population eligible for the study included all [redacted] Medicaid members enrolled in [redacted] in 2017 who had claims in the encounter data for buprenorphine. Modified HEDIS specifications were followed to determine these members' engagement of AOD treatment.

STUDY LIMITATIONS

The study was based on approved encounter data submitted by the MCOs to [redacted] and in turn sent by [redacted] o Mercer. [redacted] and Mercer are dependent on the MCOs to submit accurate and complete encounter data. Standard data validation processes enabled Mercer to compare the data to previous data and perform checks for missing or unpopulated fields. Mercer cannot guarantee the data is free of minor anomalies or missing claims, but Mercer believes the data is substantially complete, reliable and stable.

The study used only final paid/approved encounter claims, and did not attempt to research or explain denied claims or denied encounter data. Additionally, if members filled prescriptions as cash claims that were not submitted to the MCO for approval or payment, those claims were not in the encounter data and were not part of the analysis. Medicaid Fee-For-Service claims data was not included in this study. Finally, the study is limited to claims from January 1, 2017 through December 31, 2017, and cannot account for treatment engagement visits outside this date range; for this reason, it is possible that some members who appear to be less engaged in treatment may be more engaged if a wider date range were used.

4
RESULTS AND DISCUSSION

OVERVIEW

Results of the study revealed interesting similarities and differences between the members with higher/stronger engagement (quartile 4 and quartiles 3 & 4 combined) and those with lower/weaker engagement (5 visits or fewer).

Member Demographics

An analysis of member demographics illustrates that most members engaging in OUD treatment are in the 21-40 age range, Caucasian, and are fairly evenly split between male and female. Members in the higher engagement groups are also fairly evenly distributed between [redacted].

Table 2: Quartile 3 & 4

AGE RANGE	PERCENT		FEMALE	MALE		BLACK	CAUCASIAN		[redacted]	[redacted]	[redacted]
0-20	0%		0%	0%		0%	0%		0%	0%	0%
21-40	79%		36%	43%		5%	74%		22%	25%	32%
41-60	20%		14%	6%		6%	14%		3%	13%	5%
61 +	1%		0%	1%		1%	0%		0%	1%	0%

Table 3: Lowest Engagement

AGE RANGE	PERCENT		FEMALE	MALE		BLACK	CAUCASIAN		[redacted]	[redacted]	[redacted]
0-20	0%		0%	0%		0%	0%		0%	0%	0%
21-40	64%		30%	34%		8%	56%		13%	36%	14%
41-60	33%		14%	19%		9%	24%		5%	21%	7%
61 +	3%		2%	1%		1%	2%		0%	2%	1%

*Table does not display two Pacific Island and one Asian member

Providers

For this section, Mercer summarized the most-common provider found on the claims for each quartile. Also included in the table is the count of unique members in that quartile the provider is seeing.

For quartile 4 (Table 4) and quartiles 3 & 4 members (Table 5), [redacted] also are in the top five providers with the highest visit counts for both quartile 4 and quartile 3 & 4 members. Interestingly, [redacted] do not appear on the top ten providers serving members with the lowest/weakest engagement rates, and [redacted] moved from the top provider to number eight. Likewise, numerous providers with the largest number of members demonstrating poor engagement, as noted in Table 6, do not appear on the higher-engagement tables.

Mercer also notes the primary taxonomy of the top ten providers identified in the higher engagement groups are mental health related. The primary exception is [redacted]., and although the primary taxonomy is listed as Family Medicine, the second, third, and fourth taxonomy listings are mental health related (Psychologist Health Service, Clinic/Center Mental Health, and Clinic/Center Methadone Clinic, respectively) and their primary membership are those with mental health conditions.

In contrast, the primary taxonomies listed for the majority of the top ten providers treating members with lowest/weakest engagement are non-mental-health focused, such as family medicine and internal medicine.

These findings suggest certain providers and/or provider types may be more successful in keeping members engaged in behavioral health treatment. Mercer could not conclude whether the therapy services counting as engagement are addressing a co-occurring mental health condition or the substance use disorder. For those providers who appear more successful in retaining members in ongoing treatment, more study is recommended to assess whether this engagement translates to successful OUD treatment outcomes. If so, perhaps there are best practices they can identify and share with their colleagues. Because ED visits did not appear on the top 10 procedure codes list for the most-engaged members (quartiles 3&4), it is possible that outcomes related to reduced ED utilization are present. However, this and any other treatment outcomes should be interpreted with caution because of the small number of members in the more-engaged quartiles. A survey of members who have demonstrated higher/stronger engagement with these providers could further inform strategies and factors that have contributed to their successful engagement.

The implications from these findings, that behavioral health providers may be more successful in keeping members engaged, are important given the national efforts to expand access to MAT by leveraging physicians, nurse practitioners, and physician assistants in a variety of practice environments, including primary care. While these provider types can and should be part of the solution in addressing the opioid epidemic and in treating OUD, non-behavioral health providers could benefit from additional educational opportunities addressing engagement and retention best practices. These findings could also suggest that members who have proven to be more difficult to engage and retain in treatment may benefit from referral to a behavioral health provider.

Table 4: Providers Treating Quartile 4 Members

RANK	PROVIDER ID	PROVIDER NAME	PRIMARY TAXONOMY	NUMBER OF PATIENTS IN 4TH QUARTILE	NUMBER OF UNIQUE VISITS WITH PATIENTS IN 4TH QUARTILE
1	[redacted]	[redacted]	Family Medicine	5	405
2	[redacted]	[redacted]	Counselor Mental Health	2	149
3	[redacted]	[redacted]	Psychologist Group Psychotherapy	3	109

RANK	PROVIDER ID	PROVIDER NAME	PRIMARY TAXONOMY	NUMBER OF PATIENTS IN 4TH QUARTILE	NUMBER OF UNIQUE VISITS WITH PATIENTS IN 4TH QUARTILE
4	[redacted]	[redacted]	Clinic/Center Mental Health	2	98
5	[redacted]	[redacted]	Clinic/Center Adult Mental Health	2	94
6	[redacted]	[redacted]	Clinic/Center Adult Mental Health	1	91
7	[redacted]	[redacted]	Community/Behavioral Health	1	74
8	[redacted]	[redacted]	Specialist	4	36
9	[redacted]	[redacted]	Counselor Professional	1	35
10	[redacted]	[redacted]	General Acute Care Hospital	3	30

Table 5: Providers Treating Quartile 3 & 4 Members

RANK	PROVIDER ID	PROVIDER NAME	PRIMARY TAXONOMY	NUMBER OF PATIENTS IN 3RD & 4TH QUARTILE	NUMBER OF UNIQUE VISITS WITH PATIENTS IN 3RD & 4TH QUARTILE
1	[redacted]	[redacted]	Family Medicine	22	818
2	[redacted]	[redacted]	Counselor Addiction	15	643
3	[redacted]	[redacted]	Psychologist Group Psychotherapy	17	584

RANK	PROVIDER ID	PROVIDER NAME	PRIMARY TAXONOMY	NUMBER OF PATIENTS IN 3RD & 4TH QUARTILE	NUMBER OF UNIQUE VISITS WITH PATIENTS IN 3RD & 4TH QUARTILE
4	[redacted]	[redacted]	Clinic/Center Mental Health	12	446
5	[redacted]	[redacted]	Specialist	25	413
6	[redacted]	[redacted]	Clinic/Center Adult Mental Health	8	302
7	[redacted]	[redacted]	Clinic/Center Rehabilitation, Substance Use Disorder	12	281
8	[redacted]	[redacted]	Clinic/Center Adult Mental Health	6	260
9	[redacted]	[redacted]	Counselor Mental Health	4	219
10	[redacted]	[redacted]	Substance Abuse Rehabilitation Facility	14	204

Table 6: Providers Treating Members with Five Visits or Fewer

RANK	PROVIDER ID	PROVIDER NAME	PRIMARY TAXONOMY	NUMBER OF PATIENTS WITH 5 OR FEWER VISITS	NUMBER OF UNIQUE VISITS WITH PATIENTS WITH 5 OR FEWER VISITS
1	[redacted]	[redacted]	Specialist	175	468
2	[redacted]	[redacted]	Internal Medicine	60	154
3	[redacted]	[redacted]	Internal Medicine	55	132

RANK	PROVIDER ID	PROVIDER NAME	PRIMARY TAXONOMY	NUMBER OF PATIENTS WITH 5 OR FEWER VISITS	NUMBER OF UNIQUE VISITS WITH PATIENTS WITH 5 OR FEWER VISITS
4	[redacted]	[redacted]	Family Medicine	30	88
5	[redacted]	[redacted]	Family Medicine	31	86
6	[redacted]	[redacted]	Obstetrics & Gynecology	31	79
7	[redacted]	[redacted]	General Acute Care Hospital	36	50
8	[redacted]	[redacted]	Family Medicine	24	47
9	[redacted]	[redacted]	Clinic/Center Adult Mental Health	18	38
10	[redacted]	[redacted]	Clinic/Center Primary Care	14	36

Diagnosis Codes

For this section, Mercer summarized the diagnosis codes from both the primary and non-primary positions on the entire universe of engagement claims. The data layout includes 26 diagnosis code positions, so the non-primary tables summarize the diagnosis codes from positions 2 through 26.

The diagnosis codes most commonly documented among both higher engagement groups specifically identify other substance dependence/abuse (e.g., alcohol, cannabis, cocaine) in addition to OUD and heavily reflect co-occurring mental health conditions as well, such as bipolar disorder, major depressive disorder, post-traumatic stress disorder, and generalized anxiety disorder. In contrast, diagnosis codes most commonly reflected in the lowest engagement group reference unspecified co-occurring behavioral health conditions

(e.g., “other psychoactive substance use, unspecified”, “unspecified mood disorder”, “anxiety disorder, unspecified”). However, numerous co-occurring, pain-related physical health conditions, such as headache, muscle spasms, gastritis, and nausea are noted with this group of members. These findings suggest the following:

- Co-occurring mental health conditions are common in this population, and may be a reason why behavioral health providers appear more successful with engagement than non-behavioral health providers. As noted earlier, behavioral health provider types were more commonly associated with the higher/stronger engagement groups. These providers are more likely to assess for, diagnose with specificity, and address co-occurring behavioral health conditions. As noted above, further research is needed to determine if this higher engagement correlates to successful outcomes.
- Those who failed to stay engaged in treatment may be struggling with pain issues. These co-occurring pain-related diagnoses may make it more difficult to engage in treatment. This reinforces the need to identify and implement pain management interventions. The presence of pain may also reflect why these members are presenting to non-behavioral health providers rather than to behavioral health providers.
- Those who failed to stay engaged in treatment may be struggling with comorbid behavioral health conditions that are not being accurately assessed/diagnosed/treated given the lack of specificity with the diagnoses being identified. Pain can certainly lead to significant depression, anxiety, and abuse of other substances. If there are more significant comorbid behavioral health conditions also present but not being adequately addressed, that could further complicate efforts to successfully engage the member.
- Finally, the most frequently documented, pain-related diagnoses appear to be more acute in nature rather than chronic, which could possibly suggest medication-seeking behavior. If that is the case, naturally longer-term engagement in OUD treatment would be hampered given the member’s lack of motivation to change.

Table 7A: Quartile 4 Primary Diagnosis Codes

RANK	PRIMARY DX CODES	DESCRIPTION	COUNT	PERCENT OF TOP TEN
1	F1120	Opioid dependence, uncomplicated	811	68%
2	F319	Bipolar disorder, unspecified	130	11%
3	F331	Major depressive disorder, recurrent, moderate	87	7%
4	F1110	Opioid abuse, uncomplicated	71	6%
5	F4310	Post-traumatic stress disorder, unspecified	45	4%
6	F1123	Opioid dependence with withdrawal	12	1%
7	F3181	Bipolar II disorder	11	1%
8	F10239	Alcohol dependence with withdrawal, unspecified	10	1%
9	F10229	Alcohol dependence with intoxication, unspecified	7	1%
10	F332	Major depressive disorder, recurrent severe without psychotic features	6	1%

Table 7B: Quartile 4 Non Primary Diagnosis Codes

RANK	NON PRIMARY DX CODES	DESCRIPTION	COUNT	PERCENT OF TOP TEN
1	F1120	Opioid dependence, uncomplicated	298	23%
2	F1020	Alcohol dependence, uncomplicated	174	13%
3	F1220	Cannabis dependence, uncomplicated	161	12%
4	F411	Generalized anxiety disorder	143	11%
5	F4310	Post-traumatic stress disorder, unspecified	136	10%
6	F331	Major depressive disorder, recurrent, moderate	103	8%
7	F1010	Alcohol abuse, uncomplicated	93	7%
8	E782	Mixed hyperlipidemia	73	6%
9	E559	Vitamin D deficiency, unspecified	70	5%
10	I10	Essential (primary) hypertension	70	5%

Table 8A: Quartiles 3 & 4 Primary Diagnosis Codes

RANK	PRIMARY DX CODES	DESCRIPTION	COUNT	PERCENT OF TOP TEN
1	F1120	Opioid dependence, uncomplicated	4,104	80%
2	F1110	Opioid abuse, uncomplicated	286	6%
3	F1123	Opioid dependence with withdrawal	227	4%
4	F331	Major depressive disorder, recurrent, moderate	138	3%
5	F319	Bipolar disorder, unspecified	130	3%
6	F4310	Post-traumatic stress disorder, unspecified	67	1%
7	F332	Major depressive disorder, recurrent severe without psychotic features	56	1%
8	F411	Generalized anxiety disorder	37	1%
9	F1420	Cocaine dependence, uncomplicated	37	1%
10	F603	Borderline personality disorder	22	0.4%

Table 8B: Quartiles 3 & 4 Non Primary Diagnosis Codes

RANK	NON PRIMARY DX CODES	DESCRIPTION	COUNT	PERCENT OF TOP TEN
1	F1120	Opioid dependence, uncomplicated	648	23%
2	F1220	Cannabis dependence, uncomplicated	321	12%
3	F1010	Alcohol abuse, uncomplicated	311	11%
4	F1020	Alcohol dependence, uncomplicated	300	11%
5	F411	Generalized anxiety disorder	244	9%
6	F1210	Cannabis abuse, uncomplicated	241	9%
7	F17200	Nicotine dependence, unspecified	205	7%
8	F1420	Cocaine dependence, uncomplicated	178	6%
9	F4310	Post-traumatic stress disorder, unspecified	158	6%
10	F331	Major depressive disorder, recurrent, moderate	156	6%

Table 9A: Lowest-Engagement Group Primary Diagnosis Codes

RANK	PRIMARY DX CODES	DESCRIPTION	COUNT	PERCENT OF TOP TEN
1	F1120	Opioid dependence, uncomplicated	1,098	81%
2	R51	Headache	57	4%
3	F1123	Opioid dependence with withdrawal	52	4%
4	M62830	Muscle spasm of back	40	3%
5	F1990	Other psychoactive substance use, unspecified, uncomplicated	29	2%
6	K2900	Acute gastritis without bleeding	25	2%
7	F1110	Opioid abuse, uncomplicated	24	2%
8	F11288	Opioid dependence with other opioid-induced disorder	13	1%
9	F319	Bipolar disorder, unspecified	11	1%
10	F39	Unspecified mood (affective) disorder	8	1%

Table 9B: Lowest-Engagement Group Non Primary Diagnosis Codes

RANK	NON PRIMARY DX CODES	DESCRIPTION	COUNT	PERCENT OF TOP TEN
1	F1120	Opioid dependence, uncomplicated	304	43%
2	M62830	Muscle spasm of back	80	11%
3	M519	Unspecified thoracic, thoracolumbar, and lumbosacral intervertebral disc disorder	60	8%
4	F17210	Nicotine dependence, cigarettes, uncomplicated	48	7%
5	Z79899	Other long term (current) drug therapy	48	7%
6	R110	Nausea	41	6%
7	F1990	Other psychoactive substance use, unspecified, uncomplicated	35	5%
8	Z720	Tobacco use	31	4%
9	F419	Anxiety disorder, unspecified	31	4%
10	Z7151	Drug abuse counseling and surveillance of drug abuser	31	4%

Procedure Codes

For this section, using the entire universe of engagement claims, Mercer summarized the procedure code submitted on each claim.

The most commonly documented procedure codes for the higher engagement groups are heavily populated with psychotherapy visits. As noted in the tables below, 68% of the procedure codes for the Quartile 4 group and 66% of the procedure codes for the Quartiles 3&4 groups were related to psychotherapy services. In contrast, only 14% of the procedure codes for the lowest engagement member group were for psychotherapy services, while 81% of the visits were for an office visit with the prescribing clinician as reflected by the 99xxx codes.

Also noted in the top ten list of procedure codes for the lowest engagement group is Emergency Department (ED) visits. This finding suggests engagement in OUD treatment may decrease ED utilization.

Table 10: Quartile 4

RANK	PRIMARY PROC CODES	DESCRIPTION	COUNT	PERCENT OF TOP 10
1	90853	Group psychotherapy	471	46%
2	90834	Psychotherapy, 45 minutes with patient	150	15%
3	H0015	Alcohol and/or drug services; intensive outpatient	102	10%
4	H0039	Assertive community treatment, face-to-face, per 15 minutes	74	7%
5	99213	Office or other outpatient visit, est pt	69	7%
6	90837	Psychotherapy, 60 minutes with patient	54	5%
7	99214	Office or other outpatient visit, est pt	45	4%
8	99211	Office or other outpatient visit, est pt	21	2%
9	90832	Psychotherapy, 30 minutes with patient	18	2%
10	99212	Office or other outpatient visit, est pt	10	1%

Table 11: Quartile 3 & 4

RANK	PRIMARY PROC CODES	DESCRIPTION	COUNT	PERCENT OF TOP 10
1	90853	Group psychotherapy	1,759	40%
2	99213	Office or other outpatient visit, est pt	586	13%
3	H0015	Alcohol and/or drug services; intensive outpatient	473	11%
4	90837	Psychotherapy, 60 minutes with patient	426	10%
5	90832	Psychotherapy, 30 minutes with patient	381	9%
6	90834	Psychotherapy, 45 minutes with patient	321	7%
7	H2036	Alcohol and/or other drug treatment program, per diem	138	3%
8	99214	Office or other outpatient visit, est pt	131	3%
9	H0039	Assertive community treatment, face-to-face, per 15 minutes	74	2%
10	99211	Office or other outpatient visit, est pt	68	2%

Table 12: Lowest Engagement Group

RANK	PRIMARY PROC CODES	DESCRIPTION	COUNT	PERCENT OF TOP 10
1	99213	Office or other outpatient visit, est pt	715	53%
2	99214	Office or other outpatient visit, est pt	237	18%
3	90832	Psychotherapy, 30 minutes with patient	98	7%
4	99203	Office or other outpatient visit, new pt	88	7%
5	99204	Office or other outpatient visit, new pt	50	4%

RANK	PRIMARY PROC CODES	DESCRIPTION	COUNT	PERCENT OF TOP 10
6	90791	Psychiatric diagnostic eval	45	3%
7	90853	Group psychotherapy	32	2%
8	90837	Psychotherapy, 60 minutes with patient	28	2%
9	90834	Psychotherapy, 45 minutes with patient	25	2%
10	99284	Emergency Dept visit	21	2%

Drug Source: NDC (pharmacy) or HCPCS (facility)

The tables below reflect the total units of buprenorphine dispensed and whether the dispense was at an outpatient pharmacy (NDC billing) or at a facility (HCPCS). Generally, NDC billing corresponds with a single dispensing event of multiple units, such as a bottle of 30 units for 30 days, whereas HCPCS billing suggests a single unit dispensed daily, or smaller dispenses of multiple units, requiring a member to make frequent visits to an OTP.

78% of the buprenorphine received by members in quartile 4 was dispensed through prescriptions filled at a pharmacy and 22% was dispensed via HCPCS billing at an OTP. When the quartile 3 group is added, the percentage dispensed via HCPCS billing decreases to 8% and drops further to 3% for the lowest engaged member group. This implies that, as more members receive prescriptions for buprenorphine from office-based opioid treatment (OBOT) programs, engagement and retention in OUD treatment may become more challenging. There can certainly be advantages to on-site dispensing, whether on a daily or less-frequent basis, when striving to actively engage members in treatment, and these findings further support this point. However, geographic location, transportation limitations, employment demands, personal preference, and other factors can make OBOT programs more appealing for many members with OUD. For these reasons, it is vital OBOT providers incorporate counseling, other behavioral therapies, and/or peer support within their office settings or have strong referral networks to assist with ongoing engagement and other support needs.

Table 13: Quartile 4

DRUG DISPENSED AS	TOTAL UNITS	% OF TOTAL
NDC	2,612	78%
HCPCS	753	22%

Table 14: Quartile 3 & 4

DRUG DISPENSED AS	TOTAL UNITS	% OF TOTAL
NDC	14,053	92%
HCPCS	1,215	8%

Table 15: Lowest Engagement

DRUG DISPENSED AS	TOTAL UNITS	% OF TOTAL
NDC	30,824	97%
HCPCS	964	3%

Prescribing Providers

In an effort to further analyze those providers that appear to be more successful with engaging and retaining members in OUD treatment, Mercer sought to identify the prescribing clinicians who are providing the buprenorphine. Mercer hypothesized the prescribing clinicians for the members with higher/stronger engagement would align with the most commonly utilized providers noted in Tables 16 and 17, and the members with the lowest engagement would align with providers identified in Table 18. The results, however, show both the higher and lowest engagement groups are often receiving their buprenorphine prescriptions from providers likely affiliated with other providers/clinics.

Additional noteworthy findings include:

- The top prescriber for members in all groups is currently facing significant legal issues and is most likely no longer a practicing provider. Per multiple [redacted] is awaiting sentencing due to banking fraud and Medicare billing fraud. [redacted] was also the owner of the [redacted] and the [redacted], which also appear on the most common prescriber tables below. For these reasons, Mercer anticipates findings related to providers and prescribing clinicians will change significantly when more recent data is analyzed.

- It appears many of the more highly-engaged members do not get their buprenorphine prescriptions from prescribing clinicians at the same treatment facility where other behavioral health and physical health services are being provided. It is not clear why that is the case, though it is possible these other clinic settings may be reluctant to prescribe buprenorphine, may be in need of more training, tools, resources, and enhanced reimbursement, or do not have prescribing clinicians with the necessary DATA 2000 waiver or have waivered clinicians who have reached their allowable patient cap. If this is the case, perhaps the treating providers have referred these members to other providers for buprenorphine, . If referrals to other providers are necessary, however, one would anticipate these referrals be made to prescribing clinicians with a primary taxonomy of psychiatry, family medicine and internal medicine rather than obstetrics and gynecology, pediatrics, or surgery. Mercer would be interested in assessing how findings related to providers and prescribing clinicians differ when comparing NCPDP pharmacy claims encounter data and medical claims encounter data from CY 2017 with that for CY 2018.

The shading in the following tables indicates providers who do not appear in the lists above of providers commonly seeing members for engagement in treatment visits.

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[11] [redacted]

Table 16: Quartile 4

PRESCRIBER	PRESCRIBER	POSSIBLE CLINIC AFFILIATION	NUMBER OF 4TH QUARTILE MEMBERS PRESCRIBED TO	TOTAL QUANTITY DISPENSED (HCPC AND NDC)	PRIMARY TAXONOMY	NPI REGISTRY LOCATION
[redacted]	[redacted]	[redacted]	2	308	Obstetrics & Gynecology	[redacted]
[redacted]	[redacted]	[redacted]	1	45	Internal Medicine	[redacted]
[redacted]	[redacted]	[redacted]	1	297	Internal Medicine	[redacted]
[redacted]	[redacted]	[redacted]	2	59	Psychologist Group Psychotherapy	[redacted]
[redacted]	[redacted]	[redacted]	2	84	Pediatrics	[redacted]
[redacted]	[redacted]	[redacted]	3	182	Surgery	[redacted]
[redacted]	[redacted]	[redacted]	1	608	Internal Medicine	[redacted]
[redacted]	[redacted]	[redacted]	2	58	Psychiatry & Neurology Neurology	[redacted]
[redacted]	[redacted]	[redacted]	1	14	Psychiatry & Neurology Psychiatry	[redacted]

PRESCRIBER	PRESCRIBER	POSSIBLE CLINIC AFFILIATION	NUMBER OF 4TH QUARTILE MEMBERS PRESCRIBED TO	TOTAL QUANTITY DISPENSED (HCPC AND NDC)	PRIMARY TAXONOMY	NPI REGISTRY LOCATION
[redacted]	[redacted]	[redacted]	2	679	Psychiatry & Neurology Psychiatry	[redacted]
[redacted]	[redacted]	[redacted]	1	295	Psychiatry & Neurology Addiction Psychiatry	[redacted]
[redacted]	[redacted]	[redacted]	1	42	Family Medicine	[redacted]
[redacted]	[redacted]	[redacted]	1	694	Clinic/Center Adult Mental Health	[redacted]

Table 17: Quartile 3 & 4

PRESCRIBER	PRESCRIBER	POSSIBLE CLINIC AFFILIATION	NUMBER OF 3RD & 4TH QUARTILE MEMBERS PRESCRIBED TO	TOTAL QUANTITY DISPENSED (HCPC AND NDC)	PRIMARY TAXONOMY	NPI REGISTRY LOCATION
[redacted]	[redacted]	[redacted]	17	1,490	Obstetrics & Gynecology	[redacted]
[redacted]	[redacted]	[redacted]	15	1,462	Psychiatry & Neurology Psychiatry	[redacted]
[redacted]	[redacted]	[redacted]	14	880	Surgery	[redacted]
[redacted]	[redacted]	[redacted]	13	1,296	Pediatrics	[redacted]
[redacted]	[redacted]	[redacted]	8	224	Psychologist Group Psychotherapy	[redacted]
[redacted]	[redacted]	[redacted]	6	711	Family Medicine	[redacted]
[redacted]	[redacted]	[redacted]	6	572	Family Medicine	[redacted]
[redacted]	[redacted]	[redacted]	5	623	Family Medicine	[redacted]

PRESCRIBER	PRESCRIBER	POSSIBLE CLINIC AFFILIATION	NUMBER OF 3RD & 4TH QUARTILE MEMBERS PRESCRIBED TO	TOTAL QUANTITY DISPENSED (HCPC AND NDC)	PRIMARY TAXONOMY	NPI REGISTRY LOCATION
[redacted]	[redacted]	[redacted]	5	990	Clinic/Center Adult Mental Health	[redacted]
[redacted]	[redacted]	[redacted]	5	828	Obstetrics & Gynecology	[redacted]
[redacted]	[redacted]	[redacted]	4	240	Psychiatry & Neurology Psychiatry	[redacted]
[redacted]	[redacted]	[redacted]	3	131	Family Medicine	[redacted]
[redacted]	[redacted]	[redacted]	3	1,014	Psychiatry & Neurology Psychiatry	[redacted]

Table 18: Lowest Engagement

PRESCRIBER ID	PRESCRIBER	POSSIBLE CLINIC AFFILIATION	NUMBER OF PATIENTS WITH 5 OR FEWER VISITS PRESCRIBED TO	TOTAL VISIT COUNT	TOTAL QUANTITY DISPENSED (HCPC AND NDC)	PRIMARY TAXONOMY	NPI REGISTRY LOCATION
[redacted]	[redacted]	Alpha Heath Center	71	153	2,054	Obstetrics & Gynecology	[redacted]
[redacted]	[redacted]	Got-a-Doc Walk-In Medical Center	63	149	2,212	Surgery	[redacted]
[redacted]	[redacted]	Papastravos Associates Medical Imaging	55	127	679	Internal Medicine	[redacted]
[redacted]	[redacted]	Got-a-Doc Walk-In Medical Center	42	142	2,090	Family Medicine	[redacted]
[redacted]	[redacted]	Bay Health	33	117	1,199	Obstetrics & Gynecology	[redacted]
[redacted]	[redacted]	Christiana Care	33	267	5,111	Family Medicine	[redacted]
[redacted]	[redacted]	Christiana Care	29	59	949	Family Medicine	[redacted]
[redacted]	[redacted]	Amna Medical Center	25	50	515	Pediatrics	[redacted]
[redacted]	[redacted]	Brandywine Counseling & Community Services	21	51	1,047	Family Medicine	[redacted]
[redacted]	[redacted]	Seth Ivins MD	20	69	791	Family Medicine	[redacted]

5
CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

As noted in the Executive Summary, members in the higher engagement groups were more likely to receive treatment with mental health professionals such as psychologists, and their visits were overwhelmingly coded as visits for psychotherapy and addiction treatment. Members showing lower engagement levels more often received treatment from internal medicine or family practice providers, and the vast majority of their visits were coded simply as office visits. Mercer believes the higher engagement members benefit from the treatment they receive from specialized providers, which may lead to better overall outcomes and extended engagement in treatment; further study of these high-engagement members may be necessary to determine if the engagement leads to successful outcomes.

Members in both the higher engagement and lower engagement groups show very similar top-prescriber lists. This indicates that even members who are more engaged in treatment with quality mental health providers are going elsewhere for their buprenorphine prescription. Mercer believes a reluctance to prescribe, a lack of training or resources, insufficient reimbursement, a lack of authorized buprenorphine prescribers, and/or buprenorphine prescribers reaching their maximum patient capacity, may play a role.

Mercer found members in the higher engagement groups receive a higher percentage of their buprenorphine units through HCPCS billing, which generally suggests more frequent (possibly daily) in-person visits to an OTP than would units billed through NDCs at a retail pharmacy. Members in the highest engagement group received 22% of their buprenorphine units via HCPCS, while members in the lowest engagement group received 3% of their units via HCPCS. Mercer believes that the frequent-visit nature of HCPCS dispensing leads to better long-term engagement and success.

Members in the lower engagement group show three of their top 10 primary diagnosis codes and two of their top 10 non-primary diagnosis codes related to back pain, headache pain, and gastritis pain. Members in the higher engagement group do not have any pain-related codes

in their top 10 lists. This suggests lower engagement members are still suffering from pain issues, and thus are less likely to stay engaged in treatment and more likely to return to opioid use for pain mitigation.

RECOMMENDATIONS

- Mercer recommends collaboration and further study with the providers shown to be most successful in retaining members in ongoing treatment to determine if the members under their care are truly successful in treatment. If so, perhaps there are best practices they can identify and share with their colleagues. A survey of members who have demonstrated higher/stronger engagement with these providers could further inform strategies and factors that have contributed to their successful engagement.
- Mercer recommends and encourages the national efforts to expand access to MAT by leveraging physicians, nurse practitioners, and physician assistants in a variety of practice environments, including primary care. While these provider types can and should be part of the solution in addressing the opioid epidemic and in treating OUD, non-behavioral health providers could benefit from additional educational opportunities addressing engagement and retention best practices.
- Mercer recommends leveraging claims and utilization data to identify clinicians whose opioid-prescribing patterns go against clinical guidelines. Outreach to these clinicians can provide feedback to assist in creating more effective treatment options for their patients.
- Mercer recommends more intensive care coordination and intervention for members who have proven to be more difficult to engage and retain in treatment; these members may benefit from referral to a behavioral health provider.
- Mercer recommends further study, research, and collaboration with providers who dispense buprenorphine in smaller quantities though frequent in-person visits. These providers may have valuable insight into how and why they use this dispensing method rather than sending members to a retail pharmacy, and might be able to further support or refute the higher engagement indicated in this study.
- Mercer recommends [redacted] the MCOs, and other stakeholders continue to support efforts to broaden access to buprenorphine prescriptions and remove prescriber capacity limits to avoid forcing members to find a prescriber outside of their behavioral health facility.

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