MCS Advantage, Inc.
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November 16th 2018.

To: **Office of the Assistant Secretary for Planning and Evaluation, ASPE**
U.S. Department of Health and Human Services, Room 415 F
200 Independence Avenue, SW
Washington, D.C. 20201

From: **MCS Advantage Inc.**
P.O. Box 171720
San Juan, PR 00919-1720

Re: Requirement of information about Provider and Health Plan approaches to improve care for Medicare beneficiaries with social risk factors.

Dear ASPE Team:

In response to the requirement of information received on October 26th, 2018, below you will find the information from MCS Advantage Inc.

If you need additional information do not hesitate to contact us immediately.

Cordially,

Leisvelvet Vega Santos
Compliance Specialist

Overview:

MCS conducts health risk assessments through several avenues: MCS makes efforts to conduct a health assessment of all MCS Advantage members. There are efforts and strategies executed to comply with the regulation that SNP members all have a health risk assessment performed. Appropriate intervention and support take place and an accurate health risk profile is maintained and updated for each member.

The initial and annual CHRA is conducted face to face by the member's PCP or Physician, using the MCS CHRA (electronic or hard copy form) that documents the health assessment including clinical and non-clinical findings. The HRAT (CHRA) includes a medical, psychosocial, cognitive, functional and mental health assessment that guides the care management approach and assigns the IDCT. This process allows the PCP or Physician to obtain an updated health profile for their patient and immediately develop an individualized care plan.

The (CHRA) Comprehensive Health Risk Assessment tool includes the following sections to be used to identify members with potential problems:

1. Personal Information: This section shall include general information to determine the Member and Provider general information and relation.

2. Vital Signs and Body Mass Index: This section shall contain the member's vital signs, such as: blood pressure, weight, height, among others and Body Mass index (BMI), and classification such as: overweight, underweight, obesity, severe/morbid obesity and normal.

3. Care Management General Assessment: This section includes living condition and environmental assessment, health literacy assessment, benefit limitations assessment, linguistics limitations assessment and cultural beliefs limitation assessment.

4. Review of Systems: this section contains information related to a system-by-system, review of the member's body functions.

5. Physical Examination: This section contains an objective description of the patient's chief complaint, illness or injury. Also included is a Skin Breakdown Evaluation related to the Chronic Pressure Skin Ulcer and the Chronic Non – Pressure Skin Ulcer.

6. Special Needs: This section contains information related to the utilization of devices, such as: artificial limb, Insulin pump, wheelchair, among others.

7. Medical Diagnoses: This section retrieves the description of the existing medical diagnostics, neoplasm previously reported, additional medical diagnostics and new medical diagnostics and description of the current treatment for each present condition.

8. Surgical Procedure History: includes the most recent surgical procedures performed on the patient in the current and last year.
9. Recent Hospitalization History: section displays the most recent hospitalizations of the patient in the current and last year
10. Family Medical History: section collects chronic conditions present in the patient family history.
11. Behavioral Assessment: This section collects information regarding any toxic habits of the member, such as: smoking, drug dependence, and/or alcohol dependence. The 2017 version includes the following information: physical activity and nutrition.
12. Pain Assessment: this section contains information related to the member's perception of their pain and its severity, if applicable.
13. Functional Status: This section contains the member's ability to manage activities of daily living (ADL) such as bathing, dressing, eating, toileting, transferring and the availability of a primary support person if the member is unable to perform those ADLs. The 2017 version includes assessment of the IADLs.
14. Fall Risk Assessment: This section evaluates members for potential risk to fall.
15. **Psychosocial Status: This section includes an evaluation of the member's Psychosocial Status, such as: member's subjective perception of his/her overall health status and quality of life, and depression and sleep evaluation.**
16. Preventive Care Review: This section contains information related to preventive screening tests applicable according to specific medical conditions, age and gender such as: mammography, colorectal cancer screening, LDL Screening, HbA1c testing, Eye Retinal Exam bone density, among others.
17. Education: This section contains information related to education provided to the member, such as: Advanced Care Planning, smoking cessation, alcohol or drug usage, among others.
18. Referral to MCS Classicare's Care Management Programs: This section contains alternatives for referrals to Care Management Program initiatives.
19. Attachment A-Evaluation for Diabetics: This section contains information related to the medical exam for diabetic members.
20. Attachment B-Medication Review: This section contains information of the medication history of long term and chronic medications. The 2017 version includes the prescriber name and specialty.
21. Attachment C- Cognitive Assessment- This section evaluates cognitive impairment.

22. Attachment D- My Health Goals: This section contains information related to the individualized care plan that includes goals, recommendations, and the next appointment for re-evaluation.

23. Attachment E- Alcohol Screening Test: This section contains the Michigan Alcohol Screening Test for assessing alcohol abuse.

24. Attachment F-Depression Screening: This section contains the self-reported mood questionnaire, Major Depression Inventory (MDI) developed by the World Health Organization (WHO), used for assessing depression.

25. Additional attachments for Home Visit Program evaluations:
    a. Detailed Review of System and Physical Examination: This section contains detail questions that provide additional information to support care coordination.

    b. Home Safety Risk Evaluation: This is an assessment to conduct an environmental scan of the member's home to identify potential risks.

Once the information has been uploaded from the CHRA, the data is used to stratify a health risk level of each member according to the algorithm created for the stratification by risk levels: low/mild, medium/moderate, and high/severe.

Health Risk Level Stratification:

- **Information/data collected from the CHRA is scored via an automated process and used to stratify the member's health risk. Stratification is divided into high, moderate, and low risk categories across five (5) dimensions: medical, functional, cognitive psychosocial status, and mental health needs.**

- The goal of automated stratification is to optimally categorize and assign members to the appropriate interdisciplinary care team. The low and moderate levels are assigned to the standard IDCT. The high-risk population is referred to the Care Management Programs and belongs to the IDCT Complex.

- Stratification level assignment is a fluid process, allowing a member to move between stratification levels in order to meet differing levels of need across the care continuum.

- The initial stratification is run within 90 days of member enrollment.

Based on the results of the CHRA automated stratification, members are assigned to a tier and the tiers to an Interdisciplinary Care Team (IDCT) that is responsible for developing the individualized care plan for the care coordination process of each member.

- Health risk level low/mild are assigned to the IDCT Standard (IDCTS).

- Health risk level medium/moderate are assigned to the IDCT Standard (IDCTS).

- Health risk level high/severe are assigned to the IDCT Complex (IDCTC).

The CHRA tool provides for direct referral to Care Management Programs in addition to the stratification process. It also provides for the identification of members with behavioral or mental health problems for referral to Behavioral Health Care Management, to be triaged for services and/or counseling.

USE AND DISSEMINATION OF HRA INFORMATION BY THE INTERDISCIPLINARY CARE TEAM:

MCS has established two types of ICTs: Standard and Complex.

Standard: The ICT Standard is responsible for implementing the individualized standard care plans for members who meet the CHRA criteria for low/mild and medium/moderate health risk stratification levels. The ICTS develops a standard care plan with recommendations and interventions that address general health maintenance, advance directives, and mental health plus individualized goals and interventions for preventive screening tests according to age and gender, and for prevalent diseases such as: Diabetes, Cardiovascular, respiratory, CKD, ESRD, Arthritis, Osteoporosis, infectious disease, behavioral health, Episodic Mood Disorder, Hypothyroidism, Alzheimer, and others.

Complex: The IDCT Complex is responsible for developing and implementing the individualized care plans for those members who meet the criteria for high risk/severe health risk stratification level according to their CHRA. The individualized care plans for high risk/severe risk members are fully customized care plans that are developed by the Care Managers as part of the Care Management Programs initiatives based on the data collected in their CHRAs and the care management health assessments.

Each member has its own specific ICT leaded by its care manager and composed of all his/her physical and mental health providers. They communicate and interact as needed to accomplish the member's goals via phone calls, conference calls and in occasion's face to face contact with the member. Due to the complexities of dual eligible beneficiaries' clinical and social issues may require the intervention of the MCS ICT Complex permanent core members that include different clinical and **psychosocial disciplines** represented by MCS and FHC staff plus the member and its PCP.

The MCS ICT Complex permanent core members meet on a regular basis for group discussions of the most challenging cases that have been referred by Care Managers, mental health coordinators/behavioral health counselors, PCPs, or by other members of the ICT. These cases benefit from the expertise and capabilities of the ICT Complex interactive discussion to look for alternatives to overcome barriers to meet the beneficiaries' identified needs. Case discussions

include a review of the member's current issues and the specific situation that may be causing these issues, as well as his or her:

- Medical Diagnoses
- Functional status for Activities Of Daily Living
- Disability
- Utilization Patterns
- Medical Treatments
- Measures Of Rehabilitation
- PCP's Plan Of Care
- Any physical, social, economic or emotional barrier to care
- Recent Significant care transition

The members of the ICT Complex develop a series of individualized recommendations for each case discussed to be coordinated by the Care Manager, while also ensuring that the member is in agreement, and that the revised care plan incorporates member preferences.
Recommendations may include, but are not limited to:

- Referral to mental health provider
- Coordination for home visits by a physician
- Referral for social worker evaluation
- Coordination of services at home, or home care as needed
- Coordination of communication between PCP, specialist, mental health providers and social workers
- Canalization of caregiver needs through respite services
- Referrals to other MCS units for re-evaluation of operational processes that could be a barrier to clinical outcomes
- Referrals to other MCS units for re-orientation to providers regarding CPG, Model of Care, and quality issues
- Prioritization of identified problems

<u>Care Management Program:</u>

MCS Care Management Program provides a member-centric model that is designed to identify and incorporate the member's unique needs and goals into a comprehensive and cost effective, individualized plan to improve health status and quality of life. The program provides care coordination to all members and ongoing care management for the high risk population that includes decision support, member advocacy, identification and recommendation of alternative plans of care, identification and use of alternative funding and community resources. The Care Management Program incorporates key requirements from the Quality Improvement Program Requirements for Special Needs Plans (Model of Care), Medicare Improvement for Patients and Providers Act 2008 (MIPPA) and CMS guidance documents.

The program focus is a collaborative process for the medical management of beneficiaries including: The Health Risk Assessment to identify member's needs: medical, functional, cognitive, mental and psychosocial status. Development of an Individualized Care Plan with integration of physical and psychosocial needs. Communication with primary care physician and interdisciplinary care team, also conducting coordination of services, care transitions, preauthorization's and Self-care education to members. Evaluation of holistic care effectiveness.
The Care Management Program encompasses all MCS SNP enrollees who are eligible these for Medicare and Medicaid benefits and services.

All members benefit from the care management approach upon enrollment in a MCS. If there is a need for a more intense individualized care management they will be impacted by the Care Management Programs either as target members from an identified population, or as potential members from a referral source.

MCS uses the following data sources to analyze the health status and risks of members:

- Care Management Health Risk Assessment (HRA)

    - Through the HRA in a daily basics the care manager identify potential members for complex care management or health status change that may qualify to another program. The care manager collects data of each member's medical, functional, cognitive, mental and psychosocial status and risks.
    - In order to understand the needs of the SNP most vulnerable beneficiaries that participated in CM program, on an annual basis the MCS Medical Operations Efficiency and Care Management Unit, analyzes and conducts a population profile based on HRA data sources and be reported as part of MOC- SNP Population Description.

- Claims or Encounter data

    - A claims /encounter data report is generated at least monthly to identify members who may qualify for the CM Program based upon their utilization history. This includes both the frequency of encounter types and also diagnosis so that those members who are frail and /or have high risk conditions such as Diabetes with co-morbidities, Cardiovascular diseases, Heart Failure and slow progression CKD III and IV and ESRD are identified.
    - The Director of Care Management/designee reviews the report to identify target members who may benefit from the care management programs interventions.

- Hospital Discharge Data

    - The hospital admissions report is generated at least monthly to identify members who may qualify for the CM Program due to their Emergency Department utilization, admission and re-admission history.

- The Director of Care Management/designee reviews the report to identify target members who may benefit from the Care Management Programs interventions.

- Pharmacy Data

  - Pharmacy data is generated at least monthly to identify members who may qualify for the CM Program based upon their medication history which includes but is not limited to drug interactions, duplications of drugs, evaluation of medications habits, and polypharmacy.
  - Pharmacy data is reviewed at least monthly by the VP of Pharmacy Pharm D and the UM Director to identify target members who may benefit from the care management programs interventions.

- Data collected through the Utilization Management (UM) process

  - A Pre-Service Authorization Review, Hospital Admission, and Concurrent Review data is generated on going basics to identify members who may qualify for the CM Program based upon their utilization history.

- Data supplied by member or caregiver

  - Self-reported data during Customer Service calls is documented by the MCS staff and referred on an ongoing basis to identify members who may qualify for the CM Program.
  - The member will be referred if a social need is identified and /or any of the following diagnostics, diabetes with co-morbidities, CHF, Cancer, and Organ Transplant, Renal disease or ESRD is identified.
  - The Care Management programs managers reviews the referrals to identify target members who may benefit from the care management programs interventions.
- Data supplied by practitioners

  - Data supplied by practitioners is generated monthly to identify members with severe/high risk stratification level based on Comprehensive Health Risk Assessments (CHRA) submitted to the Plan. Members with Chronic Alcoholism are identified as a potential case for Behavioral Care Management Programs.
  - Once member health risk level stratification information is received, the care manager begins the care management program interventions. In the initial telephonic contact the care manager validates through the care management health risk assessments the stratification level.

MCS Care Management receives referrals from a variety of sources and regularly analyzes its available data systems to identify the potential member with physical, mental and social necessities to participate in the program. Population identification SNP and Non SNP members occurs on a monthly basis and a list is referred to MCS's Care Management Programs for complex care management follow-up. Those members who subsequently meet the criteria for complex care management are identified as most vulnerable members.

Members who experience a critical event or diagnosis shall receive timely care management services. Multiple referral avenues shall be utilized to minimize the time between when a member's need is identified and when the member receives services. The Care Management approach help members navigate the care system and obtain necessary services in an optimal setting in a timely manner.

Member self-referrals and practitioner referrals allow MCS to consider members for enrollment to care management programs. In its literature to PCPs and specialists and through member outreach, MCS provides a means for member self-referral or practitioner referral by communicating the availability of programs with contact information (e.g., telephone numbers) to members and practitioners.

The Care Management concept refers to a set of evidence-based, integrated clinical care activities that are tailored to the individual patient and that ensure each patient has his or her own coordinated plan of care and services.

The MCS Care Management includes the following activities:

- Care Management Health Risk Assessment is a continuous process to identify member's needs: medical, functional, cognitive, mental and psychosocial status.
  - Through Comprehensive Health Risk Assessments (CHRA)
  - Through Care Management Programs health assessments
  - During Care transitions
- Encourage the Members during the Initial and Follow up Phone calls
  - To participate in the programs
  - To take an active role in their own treatment to ensure their outcomes be optimal
  - To sharing information, feelings and signs and accepting health team recommendations
- Data Analysis
  - From CHRA for health risk level identification
  - From utilization data, self-reported data and data supplied by practitioner to identify the most vulnerable members for Care Management Programs
  - From hospital review data for specific Education and Wellness interventions

- Referrals
  - To appropriate ICT according to health risk level stratification from CHRA data
  - To appropriate Care Management Program including behavioral from data analysis and other clinical programs referrals

- Development of a care plan with integration of physical and psychosocial needs.
  - Standard individualized for all members stratified low or moderate.
  - Individualized for members enrolled in care management programs with complex needs
  - Care plans for transitions

- Continuous Care Management as needed
  - Follow up and documentation the quality of care, services and products delivered to the member to determine if the goals of the care plan are being achieved, or if there is any barrier and if those goals remain appropriate and realistic. This part may also be called the monitoring, reassessing, and re-evaluation phase of care management.

- Communication with Primary Care Physician and Interdisciplinary Care Team
  - Care Managers support members retain providers continuity of care by ensuring communication between physicians, specialist and other members of the care team.

- Conducting coordination of services, care transitions, pre-authorizations
  - Identifies immediate, short term, and ongoing needs, as well as where and how these care needs can be met. The plan sets goals and time frames for achieving the goals that are appropriate to the individual, and are agreed to by the member's treatment team. The Care Manager is also responsible to ensure accurate clinical information and disease or procedure-specific during the planning, and to complete all the pre-service authorizations/transition of care for members, in compliance with the organization determination process expedite and standard request. During the pre-authorization process, coordination and care management, pertinent medical information available in the electronic record is transfer to providers involve in the treatment of the member.

- Education
  - Perform educational interventions taking into consideration member's health literacy to achieve a better understanding of the condition, promote engagement, self-empowerment and informed decision making regarding their

health care. Educational interventions includes the mailing of educational material to the member related to the condition, nutrition, risk factors, treatment adherence, safety measures, living planning activities and mental health among others.

- Measuring health outcomes
  - Effectiveness of the program specific clinical measure is evaluated against established performance goals as part of the Model of Care yearly evaluation.

The Complex Care Management Programs focuses its efforts on members with chronic, catastrophic, degenerative, and disabling conditions through the complex care management initiatives. It also works planned care transitions from home to a higher level of care. This program coordinates and provides clinical care and services related to medical conditions by monitoring the medical treatment plan provided by the primary care physician or specialist. This program directs efforts to improve health care quality for their members by implementing an individualized care plan and ensuring that medically necessary care is delivered at the appropriate level of care. Through the Palliative/Terminal Care Management, the Complex Care Management Program supports the most vulnerable, frail, disabled, incurable patients with progressive and in some instances life-limiting illnesses.

The Complex Care Management Program includes initiatives such as but not limited to:

a. Chronic Kidney Disease- for Members with CKD Stage III and IV. Goal: Avoid progression of disease and cardiovascular complications, avoid ER visits, avoid admissions and readmissions, ensure timely access placement for dialysis (AVF for hemodialysis) and ease transplant evaluation.

b. Diabetes- is supported by a multidisciplinary team that is responsible for providing targeted interventions for members who have been diagnosed with diabetes with co-morbidities. The target population is members with uncontrolled diabetes at high risk/high utilization because they have one or more diabetes related conditions. Members with diabetes with a home service request are also impacted to avoid further complications. Goal: Reduce risk or avoid progression of diabetes related conditions (nephropathy, retinopathy, neuropathy, cardiovascular disease), effective diabetes self-management and avoid skin ulcers and amputations. Performance/Goal outcome: Meets the National Means on: members with HbA1c in poor control (>9.0%), members with LDL levels >100 mg/dl and members with blood pressure >140/90 mm Hg. Coordinated preventive services (HbA1 and LDL Screening, Eye Exam, Nephropathy Monitoring).

c. ESRD – for members with CKD stage V with or without dialysis. Goal: Adequacy of hemodialysis and peritoneal dialysis, anemia management, and vascular access management (AVF)

d. End of Life/Palliative Care- for members with a terminal illness and a life expectancy of 18 months or less. Goal: Transition to hospice care, avoid ER visits, hospitalizations and readmissions before transition to hospice or if member refuses hospice.

e. Frail/Fragile- for members with unstable high risk chronic conditions; at risk for fragmented care; with behavioral or social issues that put them at risk of worsening their condition. Goal: Stabilization of conditions, maximize member's functionality, avoid ER visits and admissions/ readmissions, and facilitate communication between providers.

f. Oncology- for members with cancer diagnosis in active treatment. Goal: support medical treatment at the best level of care available.

g. Pre Transplant-for members on evaluation process and/or waiting list for organ and/or bone marrow transplant. Goal: ease organ and/or bone marrow transplant process.

h. Post-Transplant -for members who have undergone organ and/or bone marrow transplant. Only within first 6 months post-transplant. Goal: avoid post-transplant complications and preservation of transplanted organ.

The Care Management Program has 2 initiatives related to care settings transitions:

i. Transition of Care - is an acute care management for members with service request for home care, SNF, CORF, Rehabilitation Centers without criteria for complex care at the time of request. Goal: complete preauthorization process of expedited and standard service requests according to timeframes; ensure successful transition of care for members.

ii. Coordination Out of Area - is an acute care management for members with request for services and/or transition of care out of Puerto Rico. Goal: complete preauthorization process of expedited and/or standard service requests according to timeframes, ensure successful transition of care for members.

As part of the Care Management Program, the Community Outreach Program is responsible to address the non-clinical needs for the high-risk SNP members that may impact their health status. Also, The Community Outreach Program is in charge of the coordination with community organizations for assistance and access to the available community resources for members/caregivers. This program facilitates access to community services for the most vulnerable beneficiaries and/or their caregiver(s).

The Community Outreach Technicians (COT) receive both internal and interdepartmental referrals. COT aims to contact a member at different times, and will vary based on referral source, but occurs within the first 30 days.
Once the member is contacted and agrees to the home visit or phone call, the COT conducts a need assessment evaluation focused on identifying non-clinical needs. If there are clinical aspects

self-reported by the member, the COT refers to the complex care management program for evaluation and intervention. The COT identifies needed services and the community agencies that will be involved, in order to coordinate the services process. Provide orientation and/or service coordination with community organizations, public /private agencies to address non clinical needs that impact health care.

The COT provides information and/or coordinates services such as but not limited to:

1. Community Transportation alternatives – Members that cannot be transported by themselves, and who do not have family or social support for transportation to meet medical needs and/or basic needs to sustain life.

2. DME not covered by Medicare or Medicaid - Members in need of durable medical equipment not covered by the plan and/or a deductible barrier, and do not have the financial means to obtain them.

3. Home nutrition services - Bedridden members with no social or family support to assist them in the preparation of food. Members who cannot prepare food for themselves and who live alone and have no family or social support to assist them in the preparation of food.

4. Housekeeping Services - Members who live alone and cannot perform most activities of daily living and no have social or family support to assist them.

5. Caregiver Respite Services - Member is a full-time caregiver or the member has a full-time caregiver in need of “respite" for their own medical appointments.

6. Recreational alternatives – Members age 60 or older, independent in their daily activities, and expressing interest in community recreation or alternatives. COT provides information on health plan exercise and nutritional activities through the "Club de Amigos Classicos" strategies.

7. Transportation Department DTOP handicap tag - Members with physical or ambulatory limitations, with multiple recurring appointments who could benefit from preferential parking either as drivers or as passengers. COT provides information and application forms for removable DTOP or government agency identifying tags.

COT also receives referrals for a home visit to obtain more information on member necessities identified by the Care Manager. They coordinate services to meet the goals of the individual care plan.

The COT provides information to the Care Manager, who establishes the interventions. The COT does the following:

1. Observation with a purpose: This occurs when the Care Manager needs more information to better identify the barrier that is affecting the appropriate management of the member’s condition.

a. Social Barriers: identify if the member lives alone in rural areas, lives in a community with high crime, socioeconomic mediators (education and/or income), lack of access to health services, or illiteracy that can be an obstacle for care.
b. Support Barriers: identify support system and the interaction amongst the individuals, attitudinal barriers of member and caregivers.
c. Physical Barriers: identify cognitive status and visual, speech, hearing, mobility and language limitations and health literacy.
d. Architectural barriers: identify member home structure features that limits the access and mobility both indoor and outdoor, the condition of streets and sidewalks, and home safety.
e. Environment Barriers: identify home maintenance problems, pest control, pet care, poor lighting, noise level, availability of goods and services, availability of public transportation.

2. Validation of Non-emergency Ambulance services criteria: additional information to ensure the proper use of ambulance services and that the member meets the criteria required.
3. Medication Inventory: This occurs when the Care Manager needs to obtain information to perform medication reconciliation, when the member presents linguistic, culture or visual limitations that prevent him from proper medication use.

The Community Outreach Unit develops and keeps updated an inventory of available Community Resources. This is a useful tool to identify needed resources in the member's geographic area. The resources could be private, nonprofit organizations, or sponsored by the government, and might have eligibility criteria which members may have to fulfill in order to qualify for the service.

CARE MANAGEMENT INTERVENTIONS

The health risk assessments (HRA) is a continuous process in which the Care Manager obtains objective data about the physical and psychosocial needs of the member. It identifies service needs and barriers for service access.

Through the HRA the care manager identify if member meets criteria and agree to participate in the care management program. The care manager develop the member's individualized care plan with problems, goals and interventions. The care plan takes into consideration the program or initiative goals, the member needs identified by the health risk assessments and the member preferences.

The care manager documents interventions related to the care plan monitoring and follow up including health assessments questionnaires, depression screening questionnaire, phone calls, service coordination's, preauthorization's determinations, letters, referrals to other programs or resources such as Mental health care coordinators, ICT Complex Committee meetings and Community Outreach. Other services offered to the members by the care managers are referrals to Customer Service Department for benefit orientation and to Grievances and Appeals Department for canalization of complains.

The Care Management Programs initiatives, goals and interventions are developed using Clinical Practices Guidelines adopted by MCS, respond to the most prevalent diagnoses, characteristics and needs in the SNP and Non SNP population as evidenced by the MCS population analysis.

- The Care Management assessment includes but is not limited to the following:
  - Initial assessment of their health status, including pain management, skin condition, and condition-specific issues
  - Documentation of their clinical history, including review of systems, physical examination, special needs and medications
  - Initial assessment of **functional status in activities of daily living and risk factors**
  - **Initial assessment of their psychosocial and mental health status including cognitive**
  - **Initial assessment of their ethnicity, health literacy, and environmental limitations**
  - **Initial assessment of preventive care status, educational needs and fall risk evaluation**
  - **Evaluation of their cultural and linguistic needs, preferences or limitations**
  - **Evaluation of their caregiver resources**
  - **Evaluation of their available benefits and services and coordination needs**
  - Evaluation of their satisfaction

All services are provided taking in consideration the member cultural, linguistic needs, preferences or limitations.

For members enrolled in care management programs, the Care Manager also provide the member and/or caregivers with educational information regarding how to maintain health and remain in the least restrictive setting, to reduce their risk of hospitalizations and unplanned transitions. The beneficiary and/or caregiver(s) are educated about indicators that show that his/her condition has improved, is stable, or worsened in each follow up intervention, not only during care transitions, but during the care management process.

The care plan goals and interventions related to education are documented as "completed" once the phone call ends. The Care Manager performed educational interventions taking into consideration member's health literacy to achieve a better understanding of the condition, promote engagement, self-empowerment and informed decision making regarding their health care. Educational interventions also includes the mailing of educational material to the member related to the condition, nutrition, risk factors, treatment adherence, safety measures, living planning activities and mental health among others.
The Care Management Program Satisfaction Survey focuses on members that have voluntarily participated in Care Management Programs as a result of being referred by one of the referral sources as a potential case for care management and/or being identified as high-risk. The Care

Management Program Satisfaction Survey is performed on a daily basis to assure member feedback about the overall program, program staff, usefulness of the information disseminated by the organization and member's ability to adhere to recommendations to identify areas of opportunities for improvement.

The Care Management Program and Individual Care Managers Specialists, are monitored on an ongoing basis for effectiveness and compliance with the care management overall process and the regulatory requirements to identify areas of opportunity for improvement. The Care Management Program overall effectiveness is evaluated to determine if it meets the needs of members and providers. Quality of service, processes, program and individual health outcomes, participant satisfaction and individual care management staff performance are some of the key elements assessed to determine the effectiveness of the program.

Care Management Data Operation 2017

The referrals from different sources were weekly monitored and evaluated assuring better identification on population meets the criteria for the different programs. An average overall of 9,800 members per month during 2017 being managed in Care Management Programs. An average of 8956.17 Advantage members managed per month.

A total of 21,474 cases managed by the care manager at the end of 2017. The most prevalent cases type were as follow: Complex Cases: Frail, Chronic Renal Condition, ESRD, Oncology, End of Life and Pre and Post-Transplant members with 34.9%, the second programs managed was CCIP for Diabetes members accounts for 24.9% of the cases, followed by 28.5% of Acute Care Coordination and Transition of Care, 9.5% were eligible for the Readmission Prevention Program and 2.1% received a Community Outreach evaluation.

The 57% (14,643) were meet the complex care managed goals and/or the transition of care was complete successfully, representing that Care Management Program managed have been effective. The members that could not be managed in the Care Management Programs were 1,688 (6.6%) that refused to participated, 736 (2.8%) that died after be referred, 1,159 (4.5%) had expired coverage after be referred, 2,081 (8.1%) was identified no criteria for participate, 4,889 (19%) were not localized despite all effort to contact and 271 (1%) for other reasons.

A total of 2,648 referred member was assisted and/or coordinated available community services representing the 12.3% member's active in Care Management Program, The 97.2% non-clinical goals was completed.

Most Vulnerable Population

A total of 14,007 D-SNP members were identified as most vulnerable members and managed for the year 2017. Representing the 14.6% of Total Special Need Program (SNP) membership (95,958).

Analysis of data obtained through Care Management HRA tools help us to understand the demographic distribution of the SNP subpopulations of most vulnerable members. The high risk member enrolled in the care management program during the 2017, 58% were female, 42% male and the average age was of 74 years.

The most frequent self-reported conditions was: Hypertension (67.7%), followed by Diabetes Mellitus (46.9%), and Cardiovascular Disease (37.2%). The prevalence of other chronic conditions members self-reported was of 16.1% Heart Failure, 20.1% renal disease, 3.1% Infectious diseases, 14.2% Cancer, 8.3% Alzheimer, 25.4% Hypothyroidism, 24.2% Respiratory conditions, 6.5% COPD and 8.2% Rheumatoid Arthritis. An estimate of 48.8% members have at least two or more chronic conditions. The 96.8% of members with chronic condition answered attend to follow up visits as recommended.

Among Special Need beneficiaries managed in the Care Management Programs in 2017, the most prevalent program were as follow: Complex cases for 40.1% of the cases, the second programs managed was CCIP with 35.3% of the cases, followed by 15.9% of Acute Management – Coordination and Transition of Care, 6.2% were eligible for the Readmission Prevention Program and 2.5% received a Community Outreach evaluation.

CONTRACT H5577-017

During 2017 a total of **6,264** members for contract **H5577-017** were identified as a high risk members, referred to the MCS Care Management Program as well and initial Health Risk Assessment was performed.

In overall member's ethnicity: 97.4% answered that were Puerto Rican Hispanics, the 2.58% Hispanics from other country and 0.30% were no Hispanics. For the question of demographics characteristics, they answers that 44.30% live in urban area, 55.28% live in rural area and 0.29% live in distances communities. The aim is to identify care access barriers and provide the highest quality of health care within local remote and rural communities, minimizing the need for patients to routinely access clinical services out with their locality.

In general, the average weight is between 120-199 pounds and the average of height is 62.7 inches (5'2") among these members. For BMI measure, 26.3% were in the normal range, while 33.8% resulted being overweight, 29.3% being obese and 7.0% being morbid obesity; increasing a risk for comorbidity for chronic condition. The most frequent self-reported condition was: Hypertension (68.5%), followed by Diabetes (47.56%) and Cardiovascular Disease (37.1%). The prevalence of chronic conditions members self-reported was of 37.1% having cardiovascular conditions, 47.5% Diabetes, 15.6% Heart Failure, 68.5% Hypertension, 19.7% renal disease, 3.1% Infectious diseases, 13.9% Cancer, 7.0% Alzheimer, 30.3% Hypothyroidism, 25.1% Respiratory conditions and 6.8% Rheumatoid Arthritis. An estimate of 48.8% members have at least two or more chronic conditions. The 97.3% of members with chronic condition answered attend to follow up visits as recommended.

Regarding medication use, the 98.6% of members answered they used their medication as recommended. The 11.4% (712) used un-prescribed medication and the 74% (524 /712) of users reports that their physician knows about it.

For the questions regarding members ER and Hospital utilization: Three month before the assessment was completed, the 37.7% (1,983/5,262) of the overall members have visited the ER, in the amount of 66.2% (1,314) one time, 22% (437) two times and 8.4% (168) three times. Three month before the assessment was completed, the 33.8% (1,776/ 5,262) of the overall members were admitted in the amount of 66.5% (1,181) one time, 25.2% (453) two times and 6.7% (118) three times.

The 6.3% of members considered their health status as excellent, 19.9% as very good, 31.6% as good, 35.3% as average, and 6.5% as poor. Understanding illness perceptions and incorporating them into the care plan is critical to effective treatment. Gives care managers the opportunity to identify and correct any inaccurate beliefs patients may have.

The 18.0% members self-report that have a living wills or health care advance directives. All member received education regarding an Advance Directive at the time a member is admitted to the Complex Care Management Program.

The 41.3% members self-report have done screening mammography and 75.0% have done a colorectal cancer screening test in the last year. Consideration of the evidence leads us to conclude that the use of clinical preventive services is suboptimal. Interventions designed to enhance the appropriate use of clinical preventive services should focus on educating physicians how to prescribe these services, and target beneficiaries for whom present gaps in care, utilization and health status are low, and risks of disease are high.

Through the assessment the care manager identified characteristic, condition, or behavior that increases the likelihood of getting a disease or injury. The 21.7% was identified as sedentary, 23.2% (1,221/5262) have high cholesterol and the 90.3% (1,103/1,221) use statins medication to lowers the level of cholesterol in the blood. The 2.7% (143) of the overall member are smoker and 25.8% (37/143) of smoker members participated in a Smoking Cessation Program. The 0.6% of the overall member Ingested alcoholic beverages and 0.1% use illicit drugs. The care manager's impact this members with Effective health education, integrating health literacy and patient activation into the development of interventions to improve health care.

In overall, the 19.1% members self-report that live alone and 80.4% live with a family member, legal tutor or authorized representative. The member that don't live alone, the 94.6% live with family member, 0.45% with legal tutor, and 3% with authorized representative. The 15.4% of members reported having limitations in performing daily living activities. Most limitations related to instrumental activities such as cleaning, cooking, laundry, shopping and going to medical appointments.
Regarding caregivers, at least 94.07% of the members reported having a primary caregiver, and 90.8% reported their caregiver is available to help, representing 3.2% in both reports more than 2016. The role of caregiver is recognized as instrumental in the care management process, and

as reported they were more available to participate in the care during 2017. In overall 99.2% responded that they have no benefit limitations.

In overall, the 9.7% members are bedridden. The 17.4% (914) have a skin lesion and 74.8% (684/914) have recommended treatment for the lesion.

In overall for questions regarding cultural and linguistic barriers: the 0.7% present language barriers, MCS had a processes and standard policies to ease the access of interpreters or document in other languages for member and caregivers. The 1.7% answered that are illiterate and the highest levels of education achieved was high school with 37.2% overall. The 2.9% never go to school, 24.7% elemental school, 17.1% middle school, 15.9% college credits and 2.0% university degree. The 0.7% have speech difficulties. Visual and Hearing barriers were identified in members with 2.1% and 1.2% respectively.

The results suggest the uniformity of the population served in terms of cultural needs and preference, when less than 0.1% members reported having cultural needs, preferences or limitations and 2.8% reported spiritual beliefs needs. The 1.2% reported additional barrier related to cognitive function limitation being lack of understanding; less than 1% had some kind of limitation in transportation. The member that cannot be transported by themselves, and who do not have family or social support for transportation, care management coordinated with community transportation alternatives or if member have benefits for transportation coordinated with a provider. MCS care managers and community outreach technicians are well trained to overcome barriers related to those needs to achieve the best possible clinical outcomes.

In overall, for questions regarding mental health status and cognitive functions: the 25.3% (1,582) members have a history of emotional condition and 88.9% (1,407/1,582) of member that have history of emotional condition were currently in treatment. For 1.5% members answered that in the past two weeks felt sad most of the time and the PHQ-9 was performed by care manager. All members with a result of 10 points or more in the PHQ-9 was referred to Behavioral Health Services.

The Care Manager identified through the initial assessment and/or in the follow up management process of a complex cases a coordination of services members needed. As part of the care plan the care manager connected the member to the appropriate providers and complete transition of care process according to outcome measures to ensure a successful transition and continuity of care for members. The 12.1% (637/5,262) of the overall members had a necessity that required a coordination of health services. For the a total 637 members identify by HRA a transition of care or services was coordinated: 16.1% members an antibiotic infusion therapy, for the 42.2% a home care, for the 11.3% a DME, for the 1.2% a physician home visit and for the 6.5% a PCP home visit. The transitions of care and coordination involves, but is not limited to, supporting and educating the member and responsible parties, and helping them transition to or remain within—the least restrictive care setting.
Regarding the educations provided during the phone call and care plan satisfaction: the 99.1% members understand the education information provided during the assessment phone call. The 98.9% member agreed and were satisfied with the individual care plan stablished. The Care

Management overall process and structure including the Community Outreach Program provides for an effective care management plan for each member needs.

CONTRACT H5577-002

During 2017 a total of **1,321** members for contract **H5577-002** were identified as a high risk members, referred to the MCS Care Management Program as well and initial Health Risk Assessment was performed.

In overall member's ethnicity: 97.52% answered that were Puerto Rican Hispanics, the 1.93% Hispanics from other country and 0.09% were no Hispanics. For the question of demographics characteristics, they answers that live 44.49% in urban area, 55.33% rural area and 0.09% in distances communities. The aim is to identify care access barriers and provide the highest quality of health care within local remote and rural communities, minimizing the need for patients to routinely access clinical services out with their locality.

In general, the average weight is between 120-199 pounds and the average of height is 63.2 inches (5'3") among these members. For BMI measure, 36.3% were in the normal range, while 32.5% resulted being overweight, 20.6% being obese and 4.7% being morbid obesity; increasing a risk for comorbidity for chronic condition. The most frequent self-reported condition was: Hypertension (64.5%), followed by Diabetes (44.4%) and Cardiovascular Disease (37.7%). The prevalence of chronic conditions members self-reported was of 37.7% having cardiovascular conditions, 44.4% Diabetes, 18.4% Heart Failure, 64.5% Hypertension, 22.3% renal disease, 3.0% Infectious diseases, 16.3% Cancer, 15.2% Alzheimer, 30.6% Hypothyroidism, 20.4% Respiratory conditions and 4.8% Rheumatoid Arthritis. An estimate of 49.6% members have at least two or more chronic conditions. The 94.9% of members with chronic condition answered attend to follow up visits as recommended.

Regarding medication use, 97.9% of members answered they used their medication as recommended. The 8.5% (112) used un-prescribed medication and the 69.6% (78/112) of users reports that their physician knows about it.

For the questions regarding members ER and Hospital utilization: Three month before the assessment was completed 38.8% (422/1,088) members have visited the ER, in the amount of 64.2% (271) one time, 21.8% (92) two times and 11.1% (47) three times. Three month before the assessment was completed 38.3% (417/1,088) members were admitted, in the amount of 67.3 % (281) one time, 22% (92) two times and 9.1% (38) three times.

The 5.5% of members considered their health status as excellent, 19.5% as very good, 31.7% as good, 34.8% as average, and 7.9% as poor. Understanding illness perceptions and incorporating them into the care plan is critical to effective treatment. Gives care managers the opportunity to identify and correct any inaccurate beliefs patients may have.
The 18.2% members self-report that have a living wills or health care advance directives. All member received education regarding an Advance Directive at the time a member is admitted to the Complex Care Management Program.

The 68.2% members self-report have done screening mammography and 30.8% have done a colorectal cancer screening test in the last year. Consideration of the evidence leads us to conclude that the use of clinical preventive services is suboptimal. Interventions designed to enhance the appropriate use of clinical preventive services should focus on educating physicians how to prescribe these services, and target beneficiaries for whom present gaps in care, utilization and health status are low, and risks of disease are high.

Through the assessment the care manager identified characteristic, condition, or behavior that increases the likelihood of getting a disease or injury. The 28.5% was identified as sedentary, 18.9% (206/1088) have high cholesterol and the 90% (185/206) use statins medication to lowers the level of cholesterol in the blood, The 2.2% (24) of the overall member are smoker and 8.3% (2/24) of smoker members participated in a Smoking Cessation Program. The 0.7% of the overall member Ingested alcoholic beverages and none use illicit drugs. The care manager's impact this members with Effective health education, integrating health literacy and patient activation into the development of interventions to improve health care.

In overall, the 14.4% members self-report that live alone, 77.1% live with family member, legal tutor or authorized representative. The member that don't live alone, the 90.7% live with family member, 1.2% with legal tutor, and 7.1% with authorized representative. The 29.1% of members reported having limitations in performing daily living activities. Most limitations related to instrumental activities such as cleaning, cooking, laundry, shopping and going to medical appointments.

Regarding caregivers, at least 95.9% of the members reported having a primary caregiver, and 93.2% reported their caregiver is available to help, 3.2% more in both reports more than 2016. The role of caregiver is recognized as instrumental in the care management process, and as reported they were more available to participate in the care during 2017. In overall 99.0% responded that they have no benefit limitations.

In overall, the 24.5% members that are bedridden. The 28.5% (310) have a skin lesion and 79.3% (246) have recommended treatment for the lesion.

In overall for questions regarding cultural and linguistic barriers: the 0.9% present language barriers, MCS had a processes and standard policies to ease the access of interpreters or document in other languages for member and caregivers. The 1.7% answered that are illiterate and the highest levels of education achieved was elemental school with 34.4% overall. The 4.0% never go to school, 20.7% middle school, 28.9% high school, 10.0% college credits and 1.9% university degree. The 0.7% have speech difficulties. Visual and Hearing barriers were identified in these members with 3.0% and 1.8% respectively.

The results suggest the uniformity of the population served in terms of cultural needs and preference, when less than 0.1% members reported having cultural needs, preferences or limitations and 1.9% reported spiritual beliefs needs. The 2.0% reported additional barrier related to cognitive function limitation being lack of understanding; less than 0.8% had some kind of limitation in transportation. The member that cannot be transported by themselves, and who do

not have family or social support for transportation, care management coordinated with community transportation alternatives or if member have benefits for transportation coordinated with a provider. MCS care managers and community outreach technicians are well trained to overcome barriers related to those needs to achieve the best possible clinical outcomes.

In overall, for questions regarding mental health status and cognitive functions: the 19.5% (258) answered that had a history of emotional condition and the 88% (229/258) of member that have history of emotional condition were currently in treatment. For 1.4% members answered that in the past two weeks felt sad most of the time, the PHQ-9 was performed by care manager. All members with a result of 10 points or more in the PHQ-9 was referred to Behavioral Health Services.

The Care Manager identifies a need for a transition or coordination through HRA and/or in the follow up management process of a complex case. Connecting the member to the appropriate providers and complete transition of care process according to outcome measures to ensure a successful transition and continuity of care for members. The 15.3% member had a necessity that required a coordination of health services. For the 1.9% members an antibiotic infusion therapy was coordinated, for the 8.51% a home care, for the 0.9% a DME, for the 0.3% a physician home visit and for the 1.9% a PCP home visit. The transitions of care and coordination involves, but is not limited to, supporting and educating the member and responsible parties, and helping them transition to or remain within—the least restrictive care setting.

Regarding the educations provided during the phone call and care plan satisfaction: the 99.2% members understand the education information provided during the assessment phone call. The 98.7% member agreed and were satisfied with the individual care plan stablished. The Care Management overall process and structure including the Community Outreach Program provides for an effective care management plan for each member needs.

CONTRACT H5577-019

During 2017 a total of **11** members for contract **H5577-019** were identified as a high risk members, referred to the MCS Care Management Program as well and initial Health Risk Assessment was performed. Do to HRA revision on March 1st 2018, the total of members in the data of new questions were difference in compare to the question transitioned of last assessment of 2016.

In overall member's ethnicity: 100% answered that were Puerto Rican Hispanics. For the question of demographics characteristics they answers that they live 50% (4) in urban area and 50% (4) rural area. The aim is to identify care access barriers and provide the highest quality of health care within local remote and rural communities, minimizing the need for patients to routinely access clinical services out with their locality.

In general, the average weight is between 100-139 pounds and the average of height is 61 inches (5'1") among these members. For BMI measure, 36.4% were in the normal range, while 18.2% resulted being overweight, 0% being obese and 27.3% being morbid obesity; increasing a risk for

comorbidity for chronic condition. The most frequent self-reported condition was: Hypertension (54.5%), followed by Respiratory Conditions (45.5%) and Cardiovascular Disease (45.5%). The prevalence of chronic conditions members self-reported was of 45.5% having cardiovascular conditions, 36.4% Diabetes, 27.3% Heart Failure, 54.5% Hypertension, 9.1% renal disease, 50.0% Hypothyroidism, and 45.5% Respiratory conditions.

An estimate of 54.5% members have at least two or more chronic conditions. The 100% of members with chronic condition answered attend to follow up visits as recommended.
Regarding medication use, 100% of members answered they used their medication as recommended.

For the questions regarding members ER and Hospital utilization: Three month before the assessment was completed, the 25% members had a visited one time the ER and 75% don't visited the ER. Three month before the assessment was completed 25% members were admitted one time and 75% were not admitted.

The 9.1% of members considered their health status as excellent, 45.5% as very good, 18.2% as good, 27.3% as average, and 0% as poor. Understanding illness perceptions and incorporating them into the care plan is critical to effective treatment. Gives care managers the opportunity to identify and correct any inaccurate beliefs patients may have. The 25% members self-report that have a living wills or health care advance directives. All member received education regarding an Advance Directive at the time a member is admitted to the Complex Care Management Program. The 25% members self-report have done screening mammography, this question was done only to women. The 75% have done a colorectal cancer screening test in the last year. Consideration of the evidence leads us to conclude that the use of clinical preventive services is suboptimal. Interventions designed to enhance the appropriate use of clinical preventive services should focus on educating physicians how to prescribe these services, and target beneficiaries for whom present gaps in care, utilization and health status are low, and risks of disease are high.

Through the assessment the care manager identified characteristic, condition, or behavior that increases the likelihood of getting a disease or injury. The 50% was identified as sedentary, 50% have high cholesterol and use statins medication to lowers the level of cholesterol in the blood. The care manager's impact this members with Effective health education, integrating health literacy and patient activation into the development of interventions to improve health care. No member smoke, Ingested alcoholic beverages or use illicit drugs.

In overall, the 27.3% members self-report that live alone, 63.6% live with family member, and 9.1% with legal tutor. The 57.1% of members reported having limitations in performing daily living activities. Most limitations related to instrumental activities such as cleaning, cooking, laundry, shopping and going to medical appointments.

Regarding caregivers, at least 90.9% of the members reported having a primary caregiver, and 90.9% reported their caregiver is available to help. The role of caregiver is recognized as instrumental in the care management process, and as reported they were more available to participate in the care during 2017. In overall 100.0% responded that they have no benefit limitations.

In overall, the 25% members are bedridden. The 25% (1) members have a skin lesion and 100.0% have recommended treatment for the lesion.

In overall for questions regarding cultural and linguistic barriers: the 9.1% present language barriers, MCS had a processes and standard policies to ease the access of interpreters or document in other languages for member and caregivers. None members answered that are illiterate and the highest levels of education achieved was elemental school with 50.0% overall, 25% high school, and 25% university degree. No speech difficulties were identified. Visual and Hearing barriers were identified in these members with 9.1% each. The results suggest the uniformity of the population served in terms of cultural needs and preference, when the no members reported having cultural needs or limitations. The 18.2% reported spiritual beliefs needs. The 9.1% reported additional barrier related to cognitive function limitation being lack of understanding; no members had limitation in transportation. The member that cannot be transported by themselves, and who do not have family or social support for transportation, care management coordinated with community transportation alternatives or if member have benefits for transportation coordinated with a provider. MCS care managers and community outreach technicians are well trained to overcome barriers related to those needs to achieve the best possible clinical outcomes.

In overall, for questions regarding mental health status and cognitive functions: the 9.1% answered that had a history of emotional condition and is currently in treatment. No members answered that in the past two weeks felt sad most of the time and the PHQ-9 don't have to be performed by care manager.

The Care Manager identifies through HRA member's necessities for a transition or coordination and/or in the follow up management process of a complex case. Connecting the member to the appropriate providers and complete transition of care process according to outcome measures to ensure a successful transition and continuity of care for members. No members was identifies with necessities that required a coordination of health services.

Regarding the educations provided during the phone call and care plan satisfaction: the 100% members understand the education information provided during the assessment phone call. The 100% member agreed and were satisfied with the individual care plan stablished. The Care Management overall process and structure including the Community Outreach Program provides for an effective care management plan for each member needs.