Attachment C

HAWAII MED-QUEST QUALITY STRATEGY 2010

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I. QUALITY STRATEGY INTRODUCTION AND OVERVIEW

The State of Hawaii Department of Human Services Med-QUEST Division (MQD) is required to develop and maintain a Medicaid Quality Strategy, with requirements specified by the Code of Federal Regulations (CFR) 438.202. The MQD takes this opportunity to assess past and current quality efforts and build a cohesive quality strategy encompassing the division's goals, objectives, interventions, and ongoing evaluation.

The Quality Strategy is comprehensive, systematic, and continuous. It will be amended as necessary to support the continuous quality improvement process, to reflect changes from legislated state, federal or other regulatory authority, and to respond to any significant changes in membership or provider demographic. The purposes of the strategy include:

- Monitoring that the services provided to clients conform to professionally recognized standards of practice and code of ethics;
- Identifying and pursuing opportunities for improvements in health outcomes, accessibility, efficiency, client and provider satisfaction with care and service, safety, and equitability;
- Providing a framework for the division to guide and prioritize activities related to quality; and
- Assuring that an information system is in place to support the efforts of the quality strategy.

MISSION

The Quality Strategy supports the Mission of the MQD, which is:
To be a leader for improving the health status of Hawaii residents and to ensure that those eligible for Med-QUEST programs have access to and receive coordinated and comprehensive high quality care.

The MQD will ensure that its clients receive high quality care by providing effective oversight of managed care organizations (MCOs) and other contracted entities to promote accountability and transparency for improving health outcomes. MQD has adapted the Institute of Medicine's (IOM) framework of quality and strive for our clients to receive care that is:

- *Safe* - prevents medical errors and minimizes risk of patient harm
- *Effective* – evidence-based services consistently delivered to the population known to benefit from them
- *Efficient* **-** cost-effective utilization that avoids waste, including waste of equipment, supplies, ideas, and energy

- *Patient-centered* - respectful of and responsive to individual patient preferences, needs, and values
- *Timely* - medically appropriate access to care and healthcare decisions with minimal delay
- *Equitable* - without disparities based on gender, race, ethnicity, geography, and socioeconomic status.

GUIDING PRINCIPLES

The MQD's quality approach aspires to the following:

Collaborative Partnerships
To a large extent in Hawaii, the same providers deliver healthcare to patients who have public or private health insurance. Improving the quality of healthcare for Medicaid clients means improving the care for all Hawaii residents and requires collaboration among State Departments, MCOs, and private sector stakeholders. Quality measure alignment among Medicaid programs and private health plans would promote evidence based care, simplify reporting and measurement for providers, and allow easier and more transparent comparison for consumers. Measures will be evidence-based, and as much as possible, validated and endorsed by the National Quality Forum (NQF). The MQD, MCOs, and partner agencies will work together on common issues, such as obesity, tobacco abuse, and early screening and intervention.

Patient-Centered Medical Home
The MQD seeks to advance the patient-centered medical home. In a medical home, the patient's personal physician and his or her team take responsibility for managing, coordinating, and integrating preventive, acute, chronic, long term, and end of life care, across all elements and continuum of a complex health care system. Care is facilitated by information technology, health information exchange, and other means to assure that patients get necessary care in a manner that is effective, safe, prompt, and culturally/linguistically appropriate.

Transparency
The MQD is committed to making information readily available to the public. Information about MCO performance on measures, reflecting satisfaction, access, chronic disease care, immunizations, cancer screening, behavioral health, etc., will be available through public reporting to promote informed choice in MCO enrollments. This information will also be communicated to the MCOs to include comparisons to benchmarks and encourage quality improvement. Information about MCO coverage of important benefits (e.g. smoking cessation programs, disease management programs), where they vary, will also be available. In addition, we plan to develop a quality section on our website.

Data Driven

A newly developed Data Warehouse will allow the MQD to have better access to encounter/claims data potentially linked with eligibility and enrollment data. This information will allow more rigorous measurement and analysis. The challenge with the variety of data sources is to put together a coherent quality picture that can be easily collected, validated, trended, and fed back to MCOs, clients, and stakeholders. The Data Warehouse is expected to integrate a variety of information that will facilitate analysis and monitoring.

Quality Based Purchasing
The MQD wants to incentivize the provision of care that improves health outcomes and disincentivize care that does not. Potential non-financial incentives include provider and MCO report cards and public reporting. Potential financial incentives include increased payment to providers and MCOs for high quality care, and disincentives include not paying for avoidable medical errors or low quality care. Incentives may also be used to encourage client healthy behaviors and adherence to recommended care. MQD is beginning to implement a public reporting and an incentive program for a subset of MCOs.

HISTORY OF MANAGED CARE

Hawaii's statewide comprehensive 1115(a) demonstration waiver began on August 1, 1994 with the QUEST program, which converted medical assistance coverage to people younger than 65 and not blind and/or disabled from fee-for-service to managed care. Beginning February 1, 2009, medical assistance coverage for the population age 65 or older and disabled of all ages has likewise been convert from fee-for-service (FFS) to managed care through the QUEST Expanded Access (QExA) program. Adults and children eligible for Medicaid receive their healthcare through QUEST and QExA. Children and pregnant women eligible for the State Children's Health Insurance Program (SCHIP) are also enrolled in the QUEST program and receive the same benefits as QUEST members. QUEST-ACE offers a limited benefits package through the QUEST MCOs to adults without dependant children below certain income and asset thresholds but not eligible for admission into the QUEST program due to the enrollment capitation of 125,000. Currently, there are three QUEST and two QExA MCOs.

Clients from the 'Medically Fragile', 'Residential Alternative Community Care', 'Nursing Home without Walls', and 'HIV Community Care' waiver programs were likewise transitioned from the FFS program into the QExA MCOs in February 1, 2009. Only the Developmentally Disabled/Mentally Retarded (DD/MR) 1915(c) waiver remains as a waiver program, providing services jointly with the QExA MCOs.

The **rationale for the implementation of a managed care** is improved access, quality, and cost-efficiency. Using managed care systems improves the care delivered to Medicaid clients by improving coordination of care, consistent application of

managed care principles, strong quality assurance programs, partnership with providers, emphasis on the medical home, and achieving cost-effective service delivery.

With nearly all of the State's Medicaid clients receiving their healthcare through MCOs, the MQD advances its reformation from a passive payer to an active purchaser. In this role, the MQD has primarily an oversight role and utilizes the MCO infrastructures to emphasize prevention, chronic disease management, and home and community based services. The MQD continually strives to improve the health status of its program clients by promoting MCO population-based care, provider quality of care, and patient healthy behaviors and self-management.

QUALITY STRATEGY DEVELOPMENT

The Quality Strategy Leadership Team (QSLT) within the MQD initiates the development of the Quality Strategy, reviews its effectiveness, and revises it accordingly. This team is a multidisciplinary group with representation from MQD branches and offices. Input is also incorporated from the External Quality Review Organization (EQRO), partner government agencies (e.g. Department of Health), providers, clients, and advocates, all providing information useful in identifying metrics and quality activities important to the Medicaid population. Also informing the Quality Strategy are assessments of the previous year's quality plan, the EQR technical report, and results from MCO reports.

EQRO Input
The annual technical report provides detailed information about MCO performance with respect to quality, access, and timeliness of care and services, which guides our Quality Strategy. Specifically, we receive information on regulatory compliance, a set of validated Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and performance improvement projects (PIPs). The EQRO also administers and reports on provider satisfaction surveys as well as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of client satisfaction, both of which inform the quality strategy. Furthermore, the EQRO assists MQD in the compiling of an MCO comparison guide of various performance measures. Importantly, the EQRO reviews and provides input on the Quality Strategy. The EQRO will also be consulted at various times during the implementation of the Quality Strategy.

Client and Provider Input
Client and provider input most directly occur through the results of client and provider surveys that are administered and reported by the EQRO. In addition, information from Member Grievance and Appeals Reports as well as Provider Complaints Reports is submitted by the MCOs and guides our Quality Strategy.

Partner Government Agency and Stakeholder Input
Reports from and regular meetings with partner agencies and stakeholders give input on statewide priorities and progress that also inform our strategy.

Public Input
Public input will be obtained by submitting the Quality Strategy for public comment initially, every 5 years, or when significant changes are made to the strategy. A public notice will be posted in major newspapers, informing the public of their access to the quality strategy document and allowing for a 30-day period for public input.

QUALITY STRATEGY IMPLEMENTATION

The MQD QSLT has the overall responsibility for the quality oversight process that governs all Medicaid programs, including the MCOs, the DD/MR waiver, and other contracts. The Leadership Team serves as the unifying point for various Quality Strategy Committees (QSCs), which track/trend report information from MCOs and other programs and provide recommendations for improvement and corrective action. Quality Collaboratives between MQD and the MCOs/programs close the loop in ensuring that remediation and systems changes are implemented.
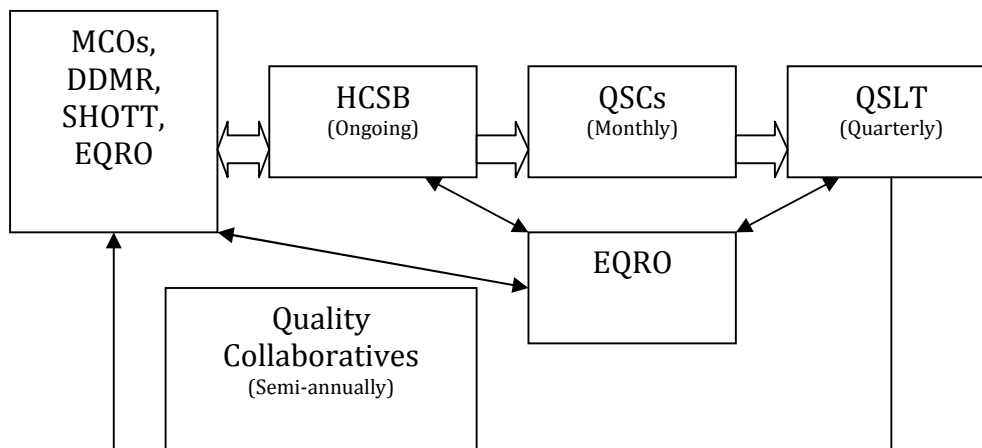
Quality Flow Process
The Health Care Services Branch (HCSB) at MQD receives and reviews all monitoring and quality reports from the MCOs, the DD/MR waiver, the State of Hawaii Organ and Tissue Transplant (SHOTT) program, and the EQRO. Standardized reporting and review tools are being developed for all MCOs and programs to allow for improved oversight, plan-to-plan comparisons, and trending over time.

Findings from the reports will be presented to various QSCs on a monthly rotation. The Committees are composed of representation from the QSLT, technical experts from the program(s) being reviewed, as well as the HCSB reviewer(s). The Committee meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The Committees will recommend feedback to the MCOs and programs, and corrective action will be requested if needed. Findings and recommendations will be properly documented.

The QLST will meet quarterly to review the findings and recommendations from the various QSCs, focusing on critical and high impact issues requiring systems change that relate to meeting established goals and objectives. Semi-annually, the Leadership Team will meet collaboratively with the MCOs and programs. These Quality Collaboratives will allow opportunity for dialogue, feedback, follow-up of corrective actions and performance improvement projects (PIPs), exchange of information, and identification of best practices.

See Figure 1 for a diagram of the quality flow process described above. Table 1 gives a summary of the membership and responsibilities of the QLST, QSCs, and quality collaboratives. Table 2 shows the quality flow process through a calendar of events.

Figure 1: Quality Flow Process Diagram:

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┌──────────┐     ┌──────────┐   ┌──────────┐   ┌──────────┐
│  MCOs,   │     │  HCSB    │   │  QSCs    │   │  QSLT    │
│  DDMR,   │ ⇄   │ (Ongoing)│ ⇒ │ (Monthly)│ ⇒ │(Quarterly)│
│  SHOTT,  │     └──────────┘   └──────────┘   └──────────┘
│  EQRO    │            ↘          ↗                 ↙
└──────────┘             ┌──────────────┐
       ↑        ↙         │     EQRO     │
       │                  └──────────────┘
┌──────────────┐
│   Quality    │ ───→
│ Collaboratives│
│(Semi-annually)│
└──────────────┘
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Table 1: Summary of the Quality Strategy Oversight:

Entities	Membership	Responsibilities
Quality Strategy Leadership Team (QSLT)	• MQD leadership from several MQD branches and offices • MQD Medical Director • EQRO consultant as needed	• Lead the development, review, and revision of Quality Strategy. • Oversight for review of quality data and monitoring reports • Oversight for quality improvement recommendations and implementation of these recommendations by MCOs and programs. • Meets quarterly and more often as needed. • Meets semi-annually in Collaboratives with MCOs and programs.
Quality Strategy Committees (QSC)	• QSLT representative • MQD technical expert(s) • MQD HCBS reviewer(s)	• Committees may include: QUEST/QExA compliance, QUEST/QExA ambulatory care quality, HCBS, Long-term Care, Inpatient Care, Mental Health • Review of quality data and monitoring reports from MCOs, programs, and EQRO. • Recommendations for corrective actions, quality improvement, and system changes. • Follow-up of corrective actions and quality improvement recommendations. • Meets in a monthly rotation.
Quality Collaboratives	• QSLT representative(s) • MQD technical expert(s) • MCO or program representative(s) • EQRO consultant	• Serves as forum between MQD and MCOs/programs for dialogue, feedback, follow-up of corrective action, PIPs, best practices.

Table 2: MQD Quality Flow Process Calendar of Events

July	August	September	October	November	December
QSC review (analysis of reports received in June) Quality Collaborative	QSC review (analysis of reports received in July)	QSC review (analysis of reports received in August) QLST meeting (review information from 2nd quarter of year)	QSC review (analysis of reports received in September)	QSC review (analysis of reports received in October)	QSC review (analysis of reports received in November) QLST meeting (review information from 3rd quarter of year)
January	**February**	**March**	**April**	**May**	**June**
QSC review (analysis of reports received in December) Quality Collaborative	QSC review (analysis of reports received in January)	QSC review (analysis of reports received in February) QLST meeting (review information from 4th quarter of year)	QSC review (analysis of reports received in March)	QSC review (analysis of reports received in April)	QSC review (analysis of reports received in May) QLST meeting (review information from 1st quarter of year)

Legend:

QSC	Quality Strategy Committee	QLST	Quality Strategy Leadership Team

GOALS AND OBJECTIVES

The MQD is focused on ensuring that its clients receive high quality care that is safe, effective, efficient, patient-centered, timely, and equitable, by providing effective oversight of health plans and other contracted entities to promote accountability and transparency for improving health outcomes.

Goal 1: Improve preventive care for women and children
Objectives:
- Childhood Immunizations: For calendar year HEDIS 2010 data, increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the 2010 Medicaid 75th percentile OR to meet/exceed the rate the is an improvement of 25% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
- Chlamydia Screening: For calendar year 2010, increase performance on the state aggregate HEDIS Chlamydia Screening measure to meet/exceed the 2010 Medicaid 75th percentile OR to meet/exceed the rate that is an improvement of

50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.

- Breast Cancer Screening: For calendar year 2010, increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the 2010 Medicaid 75th percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
- Establish baselines for the above measures for the QExA MCOs using HEDIS 2010 data.

Goal 2: Improve care for chronic illness
Objectives:
- Comprehensive Diabetes Care Measures:
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (>9) to meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<7) to meet/exceed below the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL screening to meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL control (<100) to meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<130/80) to

meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.

- o For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for eye exams to meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
- o Establish baselines for nephropathy measure for both QUEST and QExA MCOs.
- Cholesterol Screening and Control in Patients with Cardiovascular Conditions:
  - o For calendar year 2010, increase performance on the state aggregate HEDIS Cholesterol Screening measure to meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
  - o Establish baselines for LDL control (<100) in patients with cardiovascular conditions for QUEST and QExA health plans.
- Blood Pressure Control in the General Population: For calendar year 2010, increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
- Appropriate Medications in Asthma: For calendar year 2010, increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the 2010 HEDIS 75th percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75th percentile, above the state aggregate rate in calendar year 2009.
- Establish a baseline of the above measures for QExA MCOs using HEDIS 2009 data.

Goal 3: Improve client satisfaction with health plan services
Objectives:
- For calendar year 2010, increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS 2010 Adult Medicaid 75th percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2008 and the CAHPS 2010 Adult Medicaid 75th percentile, above the state aggregate rate in 2008.
- For calendar year 2010, increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS 2010 Adult Medicaid 75th percentile OR to meet/exceed the rate that is an improvement of

50% of the difference between the rate in calendar year 2008 and the CAHPS 2010 Adult Medicaid 75th percentile, above the state aggregate rate in 2008.
- For calendar year 2010, increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS 2010 Adult Medicaid 75th percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2008 and the CAHPS 2010 Adult Medicaid 75th percentile, above the state aggregate rate in 2008.
- Establish a baseline of the above measure for QExA MCOs using the 2010 Adult CAHPS survey results.

Goal 4: Improve cost-efficiency of health plan services
Objectives:
- Over the next 2 years, develop the use of Episode Treatment Groups (ETGs) to compare health plans for a variety of chronic conditions.
- Over the next 2 years, establish baseline data for hospital readmission rate in line with specifications set by the Medicaid Medical Directors Learning Network, in order to allow comparison to other states and begin quality improvement process with MCOs.
- Over the next year, explore and establish baselines for ED data from the data warehouse encounter data, to include all ED visits leading to inpatient hospitalizations.
- Improve performance on the state aggregate HEDIS 2010 Emergency Department Visits/1000 rate to meet/fall below the HEDIS 2010 10th percentile OR to meet/fall below the rate that is an improvement of 50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 10th percentile.
- Establish baseline of the above measure for the QExA MCOs using HEDIS 2009 data.

Goal 5: Monitor Home and Community Based Service (HCBS) clients who have transitioned from waiver programs into QExA health plans
Objectives:
- Increase by 5% the proportion of clients receiving HCBS instead of institutional-based long-term care services over the next year.
- Establish baseline for ED visits in HCBS clients.
- Establish baseline for hospital admissions in HCBS clients.

II. ASSESSMENT

This section addresses a) Quality and Appropriateness of Care, b) State Standards and Contract Compliance, c) Monitoring and Evaluation, and d) Health Information Technology.

QUALITY AND APPROPRIATENESS OF CARE

Race, Ethnicity, and Primary Language

Consistent with Federal Regulations, the procedure for MQD obtaining data and communicating data to MCOs include the following: The eligibility workers at MQD, while processing the application and determining eligibility, obtain information about the client's race, ethnicity, and primary language. This information is entered into the Department of Human Services Hawaii Automated Welfare Information (HAWI) eligibility system and transferred monthly to the MCOs through the health plan enrollment file (834 file). Any changes are updated and transferred to the MCOs daily via the 834 file format as well. The procedure is the same for clients receiving Supplemental Security Income. Eligibility workers at the Benefit Employment and Support Services Division (BESSD) obtain this information while processing the application and the information is transferred to the MCOs monthly and changes updated daily.

The ethnic categories in Hawaii include Hispanic (HI) and non-Hispanic (NH). Race categories include the following in the table below.

Table 3: Race Codes and Categories

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RACE CODE DATE FROM DATE TO           DESCRIPTION             FED GROUP
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 AI        010187    999999  AMERICAN INDIAN/ALASKAN NATIVE AI
 BL        010187    999999  BLACK                          BL
 CH        010187    999999   CHINESE                       AN
 FI        010187    999999  FILIPINO                       AN
 HA        010187    999999  HAWAIIAN                       NH
 JA        010187    999999  JAPANESE                        AN
 KO        010187    999999  KOREAN                         AN
 OA        010187    999999  OTHER ASIANS                   AN
 OP        010187    999999  OTHER PACIFIC ISLANDERS         NH
 SA        010187    999999  SAMOAN                         NH
 WH        010187    999999  WHITE                          WH
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Primary language categories are in the process of being updated in the HAWI system. The table below shows the current primary language codes as well as the new codes that will be added to the system.

Table 4: Primary Language Codes

Current Codes/Languages		New Codes/Languages to be added			
CA	Cambodian	AR	Arabic	MA	Malay
CC	Cantonese	AM	Aramaic	ML	Maltese
CM	Mandarin	BE	Bengali	MO	Maori
EN	English	BI	Bisayan	MR	Marquesan
FI	Ilocano	BU	Bulgarian	MS	Marshallese

FO	Filipino Other	CE	Cebuano	MK	Mon-Khmer
FT	Tagalog	CH	Chamorro	NA	Navaho
HA	Hawaiian	CU	Chuukese	NO	Norwegian
JA	Japanese	CZ	Czech	OA	Other Asian
KO	Korean	DA	Danish	OI	Other Indo-European
KS	Kosraean	DU	Dutch	ON	Other North American Indian
LA	Laotian	ES	Estonian	PW	Paiwan
OT	Other	FJ	Fijian	PP	Papuan
PA	Palauan	FN	Finnish	PE	Persian
SA	Samoan	FM	Formosan	PO	Pohnpeian
SI	Sign Language	FR	French	PL	Polish
SO	Other So. Pacific	FC	French Creole	PR	Portuguese
SP	Spanish	GE	German	RA	Rapanui
TO	Tongan	GR	Greek	RO	Romanian
UN	Unknown	GU	Gujarathi	RU	Russian
VI	Vietnamese	HE	Hebrew	SE	Serbian
YA	Yapese	HI	Hindi	SN	Sinhalese
		HM	Hmong	SL	Slovak
		HU	Hungarian	SV	Slovenian
		IB	Ibo	SW	Swedish
		IN	Indonesian	TA	Tahitian
		IR	Irish	TH	Thai
		IT	Italian	TU	Turkish
		KR	Kru	VS	Visayan
		KU	Kurdish	YI	Yiddish
		LT	Latvian	YO	Yoruba
		LI	Lithuanian		

External Quality Review (EQR) Activities and Report

MQD contracts with an EQRO to perform, on an annual basis, an external, independent review of quality outcomes of, timeliness of, and access to, the services provided to Medicaid clients by MCOs, as outlined in 42 CFR 438, Subpart E. MQD currently contracts with Health Services Advisory Group (HSAG) for EQR activities. HSAG has been the EQRO for the State of Hawaii since 2001.

The EQRO and each of its subcontractors must meet the competency and independence requirements detailed in 42 CFR 438.354. Competency of its staff is demonstrated by experience and knowledge of: a) the Medicaid program; b) managed care delivery systems; c) quality assessment and improvement methods; and d) research design and methodology, including statistical analysis. The EQRO must have sufficient resources and possess other clinical and nonclinical skills to perform EQR

activities and to oversee the work of any subcontractors. To maintain its independence, the EQRO must be governed by a board whose members are not government employees; and must not: a) review an MCO if the EQRO or the MCO exerts control over the other as evidenced by stock ownership, stock options, voting trusts, common management, and contractual relationships; b) furnish health care services to Medicaid recipients; c) perform Medicaid managed care program operations related to the oversight of the quality of the MCO on the State's behalf, except for the activities specified in 42CFR 438.358; or d) have a financial relationship with the MCO that it will review.

The EQRO is responsible to perform mandatory and optional activities as described in 42 CFR 438.358. Mandatory activities for each MCO include: a) validation of performance improvement projects; b) validation of performance measures reported as required by the State of Hawaii; and c) a review, conducted within the previous 3-year period, to determine compliance with standards established by the State with regards to access to care, structure and operations, and quality measurement and improvement. Optional activities as required by the State of Hawaii have included: a) administration of the CAHPS Consumer Survey; b) administration of a provider satisfaction survey; c) encounter data validation; and c) provision of technical assistance to the MCOs to assist in conducting activities related to the EQR activities.

For the EQR activities conducted, the EQRO will submit an annual detailed technical report that describes data aggregation and analysis, and the conclusions that were drawn as to the quality, timeliness, and access to the care furnished by each MCO. The report will also include: a) an assessment of each MCO's strengths and opportunities for improvement; b) recommendations for improving quality of health care; c) comparative information about the MCOs; and d) an evaluation of how effectively the MCOs addressed the improvement recommendations made by the EQRO the prior year.

The EQR results and technical reports will be reviewed by the appropriate Quality Strategy Committee (QSC) and the Quality Strategy Leadership Team (QSLT). The QSC will analyze the information and make recommendations for corrective actions, quality improvement and system changes to the MCOs and will monitor MCO compliance to corrective actions. The QSLT will provide oversight of implementation of quality recommendations and will review and revise the Quality Strategy accordingly.

Clinical Standards and Guidelines
The MQD uses clinical guidelines to guide its policy development. Guidelines are adapted or adopted from national professional organizations, such as the United States Preventive Services Task Force (USPSTF) for screening recommendations, the Centers for Disease Control/American Committee on Immunization Practices for immunization recommendations, the Public Health Service Clinical Practice Guidelines for tobacco cessation guidelines, and the American Academy of

Pediatrics/Bright Futures for Early Periodic Screening Diagnostic and Treatment (EPSDT) periodicity of screening and diagnostic testing.

At the same time, MQD requires contracted MCOs to adopt practice guidelines consistent with 42 CFR 438.6(h) and 422.208, which are relevant to MCO membership, based on valid and reliable clinical evidence, adopted in consultation with network providers, reviewed and updated regularly, and disseminated to all affected providers and upon request to members or potential members. MQD requires the MCOs to develop at least three clinical guidelines for medical conditions and at least 2 for behavioral health conditions. These may include asthma, diabetes, high risk pregnancy, depression, and attention deficit hyperactivity disorder, among others.

MCO compliance with Federal Regulations with regards to clinical guidelines is reviewed by the EQRO at least every 3 years.

Performance Measures
Since CMS, in consultation with the States, has not mandated specific performance measures and topics for performance improvement projects (PIPs), the MQD has identified a set of performance measures and PIP topics that address a range of priority issues for Medicaid clients. The measures have been identified through a process of analysis and trending of data within the Medicaid population, from MCO reports, and from the EQR technical report. Client and provider input, through results of client and provider surveys as well as member grievance and provider complaint reports, also guides the selection of performance measures. Reports from regular meetings with partner agencies and stakeholders also inform the selection of performance measures. Performance measures are updated each year.

Table 5: Selected HEDIS Performance Measures for 2009

HEDIS 2009						Rate	%tile
I Effectiveness of Care		Note	QUEST	QExA		Rate	%tile
Childhood Immunization Status			X	X	Combination #2	67.55%	25-50
Lead Screening in Children			X	X		59.51%	N/A
Breast Cancer Screening			X	X		51.15%	25-50
Cervical Cancer Screening			X	X		68.05%	50-75
Colorectal Cancer Screening		added 2009	X	X			
Chlamydia Screening in Women			X	X	Overall Rate	51.44%	50-75
Appropriate Treatment for children with Upper Respiratory Infection		added 2009	X	X			
Avoindance of Antibiotic Treatment in Adults with Acute Bronchitis		added 2009	X	X			
Use of Appropriate Medications for People with Asthma			X	X	Combined Rate	85.74%	25-50
Cholesterol Management for Patients with Cardiovascular Conditions		added 2009	X	X			
Controlling High Blood Pressure		added 2009	X	X			
Persistence of B Blocker Treatment after a Heart Attack		added 2009	X	X			
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Tested			X	X		76.63%	25-50
HbA1c Poor Control (>9%)			X	X		59.95%	25-50
HbA1c Good Control (<7%)			X	X		19.99%	N/A
Eye Exam (Retinal) Performed			X	X		52.32%	50-75
LDL-C Screening Performed			X	X		75.11%	10-25
LDL-C Screening Level < 100 mg/dL			X	X		26.15%	10-25
Systolic and Diastolic BP Levels < 130 / 80			X	X		31.38%	N/A
Antidepressant Medication Management			X	X	Optimal Practitioner Contacts for Medication	34.14%	90-100
Follow-Up of Care for Children Prescribed ADHD Medication		added 2009	X	X			
Follow-Up After Hospitalization for Mental Illness			X	X	7 days	32.60%	25-50
Annual Monitoring for Patients on Persistent Medications		added 2009	X	X			
Medication Reconciliation Post-Discharge		added 2009	X	X			
Use of High-Risk Medications in the Elderly		added 2009	X	X			
Osteoporosis Testing in Older Women		added 2009	X	X			
Flu Shots for Older Adults		added 2009	X	X			
Medical Assistance With Smoking Cessation		added 2009	X	X			
Pneumonia Vaccination Status for Older Adults		added 2009	X	X			
II Access/Availability of Care							
Adults' Access to Preventive/Ambulatory Health Services				X	20-44 years	76.41%	25-50
Prenatal and Postpartum Care			X		Prenatal	55.98%	0-10
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment			X	X	Initiation of AOD Dependence Treatment	48.96%	75-90
III Use of Services							
Well-Child Visits in the First 15 Months of Life			X	X	Children who received six or more visits	51.85%	50-75
Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life			X	X		60.87%	25-50
Inpatient Utilization -- General Hospital/Acute Care			X	X	Total Days/1,000 Member Months (MM)	21.12	10-25
Ambulatory Care			X	X	Total Outpatient Visits/1,000 MM	188.53	0-10
Mental Health Utilization -- Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services			X	X	Any Mental Health Services, Total %	8.57%	50-75
IV Cost of Care							
Relative Resource Use for People with Diabetes			X	X			N/A
Relative Resource Use for People with Asthma			X	X			N/A
V Health Plan Descriptive Information							
Member Months of Enrollment by Age and Sex			X	X		N/A	

STATE STANDARDS AND CONTRACT COMPLIANCE

All standards for access to care, structure and operations, and quality measurement and improvement, listed in the table below are incorporated in the MCO contracts/requests for proposal (RFPs) and in accordance with Federal Regulations. The language in the MCO contracts for each standard is in alignment with the regulations, and in some cases, more stringent than the regulations. See ***Attachment 1*** for a detailed crosswalk. The QUEST and QExA contracts are also included as ***Attachments 2 and 3*** for detailed documentation of contract language. Monitoring for each of these standards is achieved by a variety of methods, including required

reporting and EQRO compliance reviews. This monitoring is more fully detailed in the next section.

MONITORING AND EVALUATION

Monitoring and Quality Flow Process
Staff of the MQD HCBS branch reviews monitoring and quality reports from the MCOs and programs. During regularly scheduled meetings, the QSCs review and analyze the data received, root causes, barriers, and improvement interventions. Feedback is provided to the MCOs and programs, and corrective action is requested if needed. The Committees also review and suggest changes to the reporting templates and monitoring mechanisms as needed. The QSLT in regular meetings review the findings and recommendations from the various QSCs and focus on critical issues requiring systems changes. The Leadership Team regularly meets in collaboratives with the MCOs and programs to provide opportunity for dialogue, feedback, follow-up of corrective actions and PIPs, exchange of information, and identification of best practices. This flow process is fully detailed under the Quality Strategy Implementation Section.

Sources for Monitoring and Quality Improvement
MCO Monitoring Reports: These are contractual reporting required from MCOs. MQD is standardizing report templates as well as review tools for each required report. These include reports on Provider Network and Credentialing, Authorization Denials, Member Grievances, Provider Complaints, Timely Access, Availability of Services, Claims Payment, Call Center, Case Management, among others. See *Attachment 4 and 5* for the most recent QUEST and QExA MCO Reporting Calendars. Reporting calendars are updated annually. The DD/MR program also has required reporting. Please refer to *Attachment 6* for reporting details.

EQRO Technical Report: Each year, the EQRO technical report compiles and analyzes results from mandatory and optional activities performed that year to monitor the MCOs. These include compliance reviews of standards on access, structure and operations, and quality measurement and improvement; validation of PIPs; validation of performance measures; and consumer satisfaction surveys. It may also include provider satisfaction surveys and encounter data validation if performed. The report includes recommendations for MCO quality improvement, comparative information about the MCOs, and an evaluation of how effectively the MCOs addressed improvement recommendations from the EQRO in the prior year.

Compliance Audit Report: This is the full report submitted by the EQRO summarizing the findings for each MCO on compliance reviews of standards on access, structure and operations, and quality measurement and improvement. It contains the analysis of findings as well as recommendations for corrective action if needed.

CAHPS Survey Report: The EQRO administers and analyzes the CAHPS survey for the MCOs, alternating each year between children and adults. The report summarizes the findings for each MCO on performance on the CAHPS surveys. It contains the analysis of findings as well as recommendations for improvement.

Provider Survey Report: The EQRO administers and analyzes a Provider Survey for providers of the MCOs every other year. The report summarizes the findings for each MCO on performance on the provider surveys. It contains the analysis of findings as well as recommendations for improvement.

HEDIS Results: The MQD requests HEDIS data from the MCOs annually. These are tracked and trended. They are used for comparisons among MCOs, discussed collaboratively among MCOs to promote sharing of best practices, and may serve as a basis for public reporting and financial incentive programs. Approximately six of these HEDIS measures are validated by the EQRO annually and included in the EQRO Technical Report.

Performance Improvement Project Reports: The EQRO validates two PIPS per MCO each year. The report summarizes the findings for each MCO on the validated PIPs. It contains the analysis of findings as well as recommendations for improvement. Technical assistance is provided to the MCOs for PIPs based on the report recommendations.

MCO Consumer Guide / Report Card: Based on CAHPS and HEDIS measures, the MQD (with assistance from the EQRO) recently compiled a report card comparing the performance of the QUEST MCOs on selected measures. This guide was distributed to the MCOs to promote transparency and sharing of best practices. The guide will continue to be generated on a regular basis and expanded to QExA MCOs. It will also be posted on the MQD website and eventually distributed to clients during open enrollment, to partner state agencies, and to stakeholders.

Encounter Data: All MCOs submit encounter data to MQD. These are stored in the claims system as well as the data warehouse. These encounter data will be used to generate information to monitor measures on a variety of clinical performance measures, services, and access. In the past, encounter data validation was performed by the EQRO on QUEST MCOs. As the data warehouse becomes more used, validation of the encounter data that feeds the data warehouse will be an important optional EQRO activity to perform.

The grid below summarizes monitoring for the required standards.

Table 6: Monitoring Mechanisms and Frequency

Monitoring Mechanism	MCO and program Reports	EQRO Technical Report	Compliance Audit Report	CAHPS Survey Results	Provider Survey Results	HEDIS Validation /Reporting	Validation of PIPs	MCO Report Card	Encounter Data
Frequency	Various Timeframes	Annual	At least once in 3 years	Annual	Every other year	Annual	Annual and Ongoing	Ongoing	Ongoing
Access to Care Standards									
Availability of Services	X	X	X	X					X
Delivery of Network Adequacy	X	X	X	X	X				
Timely Access to Care	X	X	X	X			X	X	
Cultural Considerations	X	X	X	X					
Primary Care and Coordination / Continuity of Services	X	X	X	X	X				
Special Health Care Needs	X	X	X	X		X			
Coverage and Authorization of Services	X	X	X	X	X				
Emergency and Post Stabilization Services		X	X						
Structure and Operational Standards									
Provider Selection and Credentialing	X	X	X		X				
Confidentiality		X	X	X					
Enrollment and Disenrollment		X	X						
Grievance Systems	X	X	X						
Sub-contractual Relationships and Delegation		X	X						
Quality Measurement and Performance Improvement Standards									
Practice Guidelines		X	X			X			
Quality Assessment and Performance Improvement Program		X	X						
Health Information Systems		X	X						X
Performance Improvement Projects		X				X	X		
Performance Measurement		X				X	X	X	X

Non-Duplication Strategy

The non-duplication regulation provides states the option to use information from a private accreditation review to avoid duplication with the review of select standards required under 42 CFR 438.204(g). The standards that may be considered for this deemed compliance as referenced in 438.204(g) are those listed in Subpart D of the regulations for access to care, structure and operations, and measurement and improvement. MQD acknowledges that the activities required under 438.240(b)1&2 (for conducting PIPs and calculating performance measures) are an option for deeming only for plans that serve only dual eligible clients and therefore does not apply to our contracted MCOs.

Hawaii Revised Statute 432E-11 requires that managed care plans doing business in Hawaii become accredited by a national accrediting organization. Currently, the QUEST MCOs are accredited by either National Committee for Quality Assurance

(NCQA) or URAC. The QExA MCOs have not been operating in Hawaii for sufficient time to seek accreditation but plan to be accredited by either NCQA or URAC as well no later than January 1, 2012.

Although MQD has not fully implemented the non-duplication strategy, it has begun work on establishing guidelines and processes, with guidance and assistance from the EQRO, by which the non-duplication strategy may be implemented. The proposed process includes:
- MQD identifies deemable standards and with assistance from the EQRO, verifies the crosswalks to ensure that all federal, state, and contractual requirements pertaining to the deemable standards are met.
- The MCO must have achieved full compliance on deemable standards through a prior State EQRO review.
- The MCO must be fully accredited by a CMS approved organization.
- The MCO must be reviewed by the CMS approved accrediting organization and achieve full compliance with the deemable standards.
- The MCO must provide the accreditation review results to MQD.
- The MQD will in turn provide the review results to the EQRO.
- The EQRO uses the results in the State's annual EQR report.

The EQRO will not duplicate the review of specified deemable standards if all the criteria above are met. However, if there are certain federal, state, or contractual requirements that do not match the accreditation standards, the EQRO will perform a limited review of those requirements in addition to reviewing the accrediting organization's review results for the specified standards.

The first two standards being considered include 'Credentialing' and 'Clinical Practice Guidelines', with additional standards to be considered in the future. See **Attachment 7** for further details on EQRO recommendations regarding the non-duplication strategy and crosswalks for the two standards being considered.

Home and Community Based Services (HCBS) Monitoring and Quality Improvement

Since February 2009, when the aged, blind, and disabled clients were transitioned from the FFS program into the QExA MCOs, the clients from the 'Medically Fragile', 'Residential Alternative Community Care', 'Nursing Home without Walls', and 'HIV Community Care' waiver programs were likewise transitioned. Only the DD/MR waiver remains as a waiver program, providing services jointly with the QExA MCOs. With these transitions, MQD is committed to monitoring the provision and quality of HCBS services, both in the QExA MCOs as well as the DD/MR waiver. The attached grid, **Attachment 6** details a quality monitoring program with performance measures that span the six assurances and sub-assurances to include Level of Care, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability.

HEALTH INFORMATION TECHNOLOGY

In accordance with 42 CFR 438.42, each MCO will maintain a health information system that collects, analyzes, integrates, and reports data. The system will provide information in areas including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The data must be collected on enrollee and provider characteristics, and on services furnished to enrollees through an encounter data system.

MQD expects that the MCOs submit encounter data at least once per month and install the MQD-approved software to allow for secure transfer of the data. The submissions must meet specified criteria for timeliness, accuracy and completeness.

- Timeliness – Eighty percent (80%) of the encounter data shall be received by MQD no more than one-hundred twenty (120) days from the date that services were rendered and ninety-nine percent (99%) within (15) months from the date of services.
- Accuracy and Completeness – The data and information provided to MQD shall be accurate and complete. Encounter data will be certified and represent services provided to QUEST and QExA enrollees only and be complete with no material omissions.

MQD will impose financial penalties or sanctions on the MCO for inaccurate, incomplete and late submissions of required data, information and reports.

As specified in CFR 438.204(f), the Hawaii Prepaid Medical Management Information System (HPMMIS) supports MQD's administration of the QUEST and QExA programs and provides for the following: a) enrollment processing; b) encounter record processing; c) claims processing; d) premium collection; e) per capita payments; and f) related tracking and reporting.

Information from HPMMIS is utilized to produce reports, which identify and aid in the investigation of provider abuse or misuse. The recent development of a Data Warehouse will enhance MQD's efforts in this area. The Data Warehouse will also enhance efforts in quality improvement as it will enable MQD to monitor HEDIS-like quality and utilization measures for specific populations (HCBS clients, DD/MR recipients, elderly clients, among others) outside of MCO annual HEDIS reporting. Through the Data Warehouse, the MQD can also monitor utilization and cost-efficiency through the tracking of Episode Treatment Groups.

In Hawaii, the use of health information technology has expanded to include an online EPSDT form, which provides a database of previous vaccines, screenings, and referrals, and will provide prompts and alerts for services that are due. This pilot

project also encompasses the collection of all EPSDT data, whether submitted electronically or through a paper form, into the online database and allows MQD to track and trend clinical information associated with EPSDT exams. Connectivity between provider electronic health systems and the EPSDT database to facilitate submission of EPSDT data is actively being explored. Connectivity among the State's Vaccine for Children's program, the Immunization Registry, and the EPSDT database is also being pursued. This connectivity will prevent the duplication of providers entering immunization information into the EPSDT online system as well as the Immunization Registry and/or Vaccines for Children database.

Although in its infancy, the proposed development and implementation of a statewide health information exchange network will give health care professionals quick access to all available records and has the potential to improve health care quality by preventing medical errors, increasing the efficiency of care, reducing unnecessary health care costs, decreasing paperwork and expanding access to affordable care. MQD is vital part of these discussions.

III. IMPROVEMENT AND INTERVENTIONS

Interventions for improvement of quality activities are varied and based on the review and analyses of results from each monitoring activity. As results from assessment activities are produced, it is likely that MQD will be able to further and more clearly define interventions for quality improvement as well as progress towards objectives.

INTERVENTIONS

State Agency Collaboration
MQD is in regular communication with the Department of Health's (DOH's) branches. These include the various Chronic Disease Prevention and Control Branches for Asthma, Diabetes, and Tobacco, the Maternal and Child Health Programs, the Mental Health Divisions, and the Developmental Disabilities Division, among others. The MCO performance on measures related to chronic diseases, maternal and child health, mental health, or the DD/MR waiver may trigger discussion with DOH to collaborate on assisting the MCOs in improving their performance. DOH branches also benefit from these collaborations since their grant requirements often include education of providers and patients that can be facilitated by the MCOs. The MQD, MCOs, and DOH branches often work together on common issues, such as obesity, tobacco abuse, and early screening and intervention.

MCO Collaboration

The collaborative relationship between MQD and the MCOs has been important in fostering improvement interventions. Monthly meetings occur with MQD and the QUEST MCOs as well as with MQD and the QExA MCOs. There are also regular medical director meetings that bring together the MQD medical director with the medical directors of the QUEST and QExA MCOs. Sharing of common problems, monitoring activities, and performance measures occur in these meetings, and these collaborations result in the sharing of best practices. In addition, MQD will be instituting Quality Collaboratives, bringing together the QLST and the MCOs, allowing opportunity for dialogue, feedback, follow-up of corrective actions and PIPs, exchange of information, and identification of best practices.

Performance Measure Validation
Performance measures are tracked and trended. The information is used to focus future quality activities and direct interventions for existing quality activities. MCOs performing poorly in certain performance measures are expected to conduct root cause analyses and causal barrier analyses to identify appropriate interventions. Technical assistance is provided to the MCOs to assist in these processes. The EQRO, in the review of performance measures, offers recommendations for improvement to the MCOs and follows-up to make sure that these recommendations are implemented.

Six HEDIS performance measures per MCO are validated during the EQR process, with corrective action required for lack of improvement. In active development is the use of a 'report card' to allow performance on selected measures to be transparent. An Incentive/Disincentive Program has also been established to incentivize/disincentivize the MCOs performance, initially for QUEST MCOs, and later expanding to the QExA MCOs. A dollar amount is withheld from MCO capitation payments and returned when performance measure goals are met.

During review and discussion of performance measures at the QSCs and QSLT meetings, opportunities are sought to implement cross- organizational and inter-agency interventions.

Performance Improvement Projects
A PIP is intended to improve the care, services, or member outcomes in a focus area of study. MQD selects certain PIP topics to be collaboratively performed by the MCOs, and the MCOs also select topics individually that address specific areas of concern. The MQD/HCSB works with the EQRO and the MCO to guide the selection of the PIPs. The current mandatory PIP topics for the QUEST MCOs are focused on Childhood Obesity and Access to Care. A third PIP related to a HEDIS clinical performance measure is chosen by the QUEST MCOs. For the QExA MCOs, the mandatory PIP is focused on HEDIS clinical performance measure. The QExA MCO selects a second clinical or non-clinical PIP.

The general expectations for PIPs include:
Year 1: PIP development process, appropriate study topic, clearly defined study question and indicators, correctly identified study population, baseline results, valid

sampling methods, accurate and complete data collection, analyses identify interventions for the re-measurement year;

Year 2: Interventions implemented and results reported;

Year 3: Re-measurement and ongoing improvement with adjustment in interventions as appropriate;

Year 4: Re-measurement demonstrating ongoing improvement or sustainability of results; and future years to be determined based on results, sustainability, and member needs.

The EQRO will validate two PIPs per MCO each year. Results are expected to demonstrate progress toward achievement of the identified goal. For areas of noncompliance, technical assistance will be provided if needed, and corrective action plans can be required and monitored.

During review and discussion of PIPs at the QSCs and QSLT meetings, opportunities are sought to implement cross-organizational and inter-agency interventions.

Public Reporting

The MQD is actively implementing a public reporting mechanism, which includes a variety of performance measures, displayed by MCO, in a simple and understandable 'report card' or 'consumer guide'. This guide allows a comparison of the MCOs across a variety of measures and can be distributed to clients, providers, and stakeholders. The guide has been developed for QUEST MCOs and will be expanded to QExA MCOs as they become more established. Implementation will include the creation of a consistent process to distribute these public reports.

Financial Incentives and Disincentives

A financial incentive/disincentive program has been developed for QUEST MCOs and will be expanded to include QExA MCOs as they become more established. The incentives involve a variety of HEDIS and CAHPS performance measures. A dollar amount is withheld from the MCO capitation payments and returned as the performance measure goals are met.

MCO Sanctions

Sanctions may be imposed on MCOs upon failure to meet reporting requirements. When corrective action is required, sanctions may also be imposed when timelines and activities for the correction action are not met. Sanctions are written into the MCO contracts and are used when other interventions have failed.

HCBS Quality Improvement Interventions

Refer to **Attachment 6** for more details. The grid details a quality monitoring program with performance measures and interventions that span the six assurances and sub-assurances to include Level of Care, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability.

EPSDT transformation grant and MCO collaboration

The EPSDT transformation grant is a pilot project that includes the development and implementation of an online EPSDT system that allows providers to submit EPSDT data electronically. The system provides a database of previous vaccines, screenings, and referrals, and will provide prompts and alerts for services that are due. EPSDT data whether submitted electronically or through a paper form, is captured into this database and allows MQD and the MCOs to track and trend clinical information associated with EPSDT exams, and will allow the MCOs to target education to providers and members based on the information.

PROGRESS TOWARDS OBJECTIVES

Efforts are ongoing to promote transparency and sharing of best practices among the QUEST MCO administrators and clinical leadership. Active EQRO and MQD technical assistance are given to promote quality improvement processes related to these measures. Increasing collaboration has been established with DOH Chronic Disease Branches, and there are renewed efforts by DOH to work with MCOs directly. Recently for the first time, public reporting and financial incentives/disincentives are being implemented for QUEST MCOs, and it is expected that future results for these measures will improve. The new QExA MCOs will be undergoing measurement for the first time and establishing baselines.

Goal 1: Improve preventive care for women and children
For the measures under Goal 1, there is baseline data for the QUEST MCOs who have been submitting HEDIS data to MQD. The figure below shows data from the last three years. The large increase for the Immunization measure was the increased efforts in data collection using the hybrid methodology with data collected from chart reviews as well as administrative data. Both Chlamydia Screening and Breast Cancer Screening have had small increases over the years that MQD would like to sustain. There have been recent interventions with the QUEST MCOs, including the move to public reporting (all three measures) as well as financial incentives/disincentives (Immunization and Chlamydia measures), which should support further improvements. The QExA MCOs are establishing baselines this year.
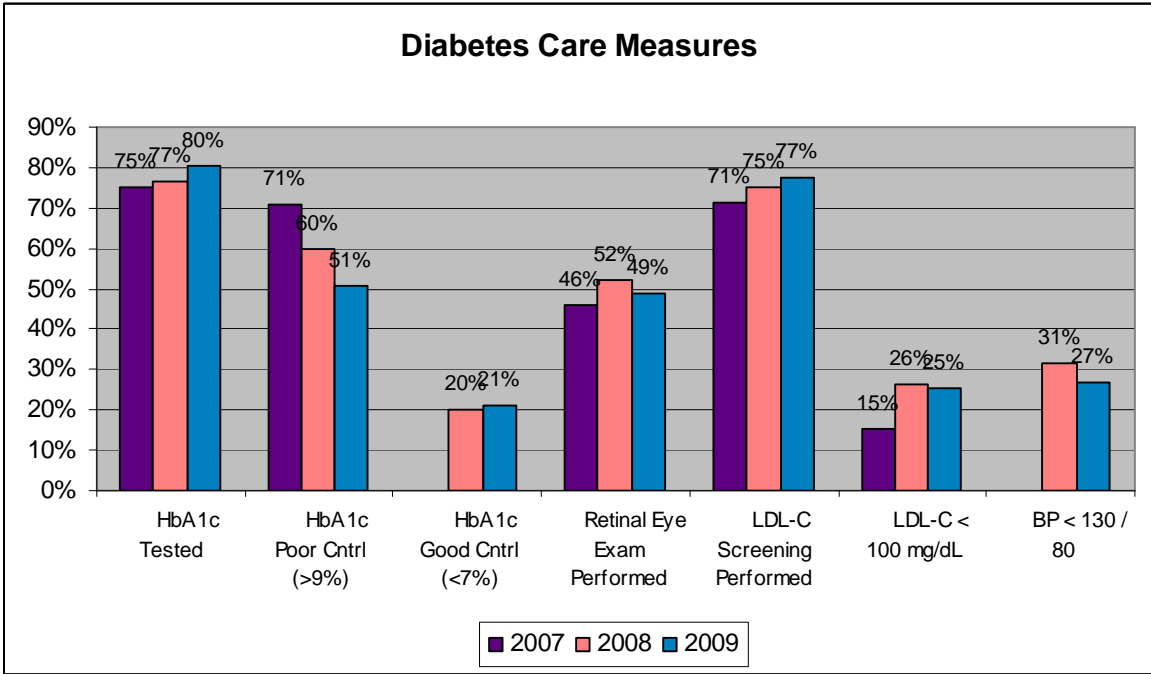
Figure 2: QUEST MCO Baseline for Goal 1 Objectives

Preventive Measures
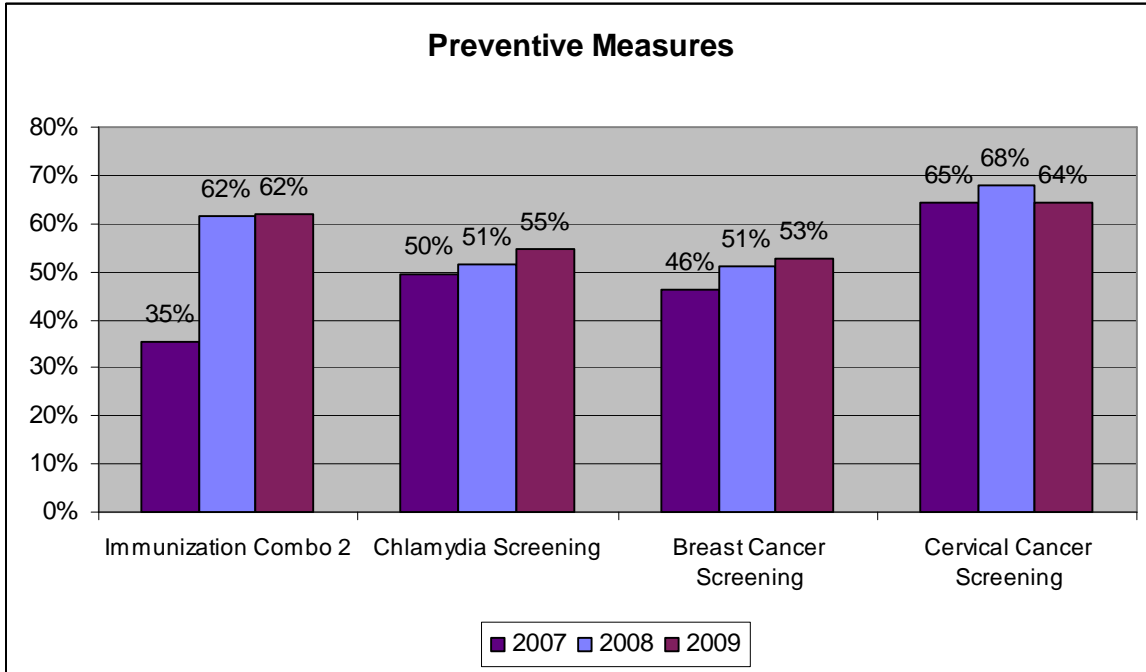
Goal 2: Improve care for chronic illness

For the measures under Goal 2, the most robust baseline data is for the Diabetes Care Measures for the QUEST MCOs who have been submitting HEDIS data to MQD. Figure 3 below shows data from the last three years. There are multiple areas for improvement, including HbA1c, LDL, and blood pressure control in diabetes patients. The LDL control in diabetes patients is included in the new financial incentive/disincentive program for the QUEST MCOs this year. All of the diabetes care measures are included in recently developed QUEST MCO consumer guide/report card.

Figure 3: QUEST MCO Baseline for Goal 2 Diabetes Care Objectives

Diabetes Care Measures

	HbA1c Tested	HbA1c Poor Cntrl (>9%)	HbA1c Good Cntrl (<7%)	Retinal Eye Exam Performed	LDL-C Screening Performed	LDL-C < 100 mg/dL	BP < 130 / 80
2007	75%	71%		46%	71%	15%	
2008	77%	60%	20%	52%	75%	26%	31%
2009	80%	51%	21%	49%	77%	25%	27%

The asthma measure also has baselines for QUEST MCOs (See Figure 4). This measure is also included in the newly developed QUEST MCO consumer guide/report card.

Figure 4: QUEST MCO Baseline for Goal 2 Asthma Care Objectives

Use of Appropriate Medications for People with Asthma

2007	2008	2009
84%	88%	89%
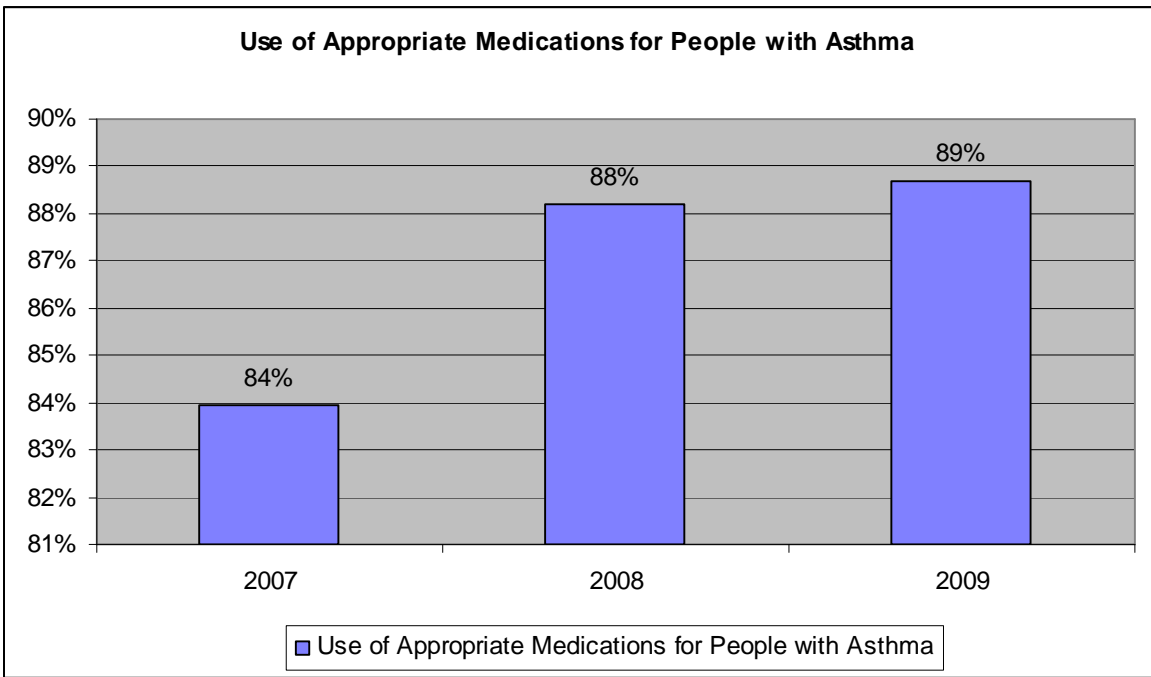
The measures for cholesterol screening and control in patients with Cardiovascular Conditions as well as Blood Pressure Control in the general populations are new

measures with limited baselines only from the QUEST MCOs in 2009. In 2009, the QUEST MCO aggregate for Cholesterol Screening in cardiovascular patients was 83% and for Blood Pressure Control in the general population was 30%. There is no baseline for LDL cholesterol control in cardiovascular patients, and QUEST MCOs are establishing this baseline this year.

The QExA MCOs are establishing baselines for all these measures this year.

Goal 3: Improve client satisfaction with health plan services
The measures for client satisfaction come from the CAHPS survey, administered for adults and children in alternate years. The measure in the adult CAHPS for 'Getting Needed Care' is included in the new QUEST MCO financial incentive/disincentive program. These satisfaction measures are also included in the recently developed consumer guide/report card. The QUEST MCO aggregate 2008 baseline rates for the selected Adult CAHPS measures are shown in Table 7 below. The QExA MCOs are establishing baselines for these measures.

Table 7: QUEST MCO 2008 Baseline for Goal 3 Satisfaction Measures

Getting Needed Care	2.218	25th-49th CAHPS Adult 2008 Medicaid Percentile
Rating of Health Plan	2.404	50th-74th CAHPS Adult 2008 Medicaid Percentile
How Well Doctors Communicate	2.578	50th-74th CAHPS Adult 2008 Medicaid Percentile

Goal 4: Improve cost-efficiency of health plan services
The use of ETGs is in the beginning stages of development and no baselines are available. Examining readmissions is also in the beginning stages of development and no baselines are yet available. Below in Figure 5 are the baselines for ED utilization measures from HEDIS for the QUEST MCOs. MQD is currently exploring ED visits from encounter data, including ED visits resulting in inpatient hospitalizations, and will be establishing baselines and goals based on these baselines. The QExA MCOs are establishing baselines for ED measures.

Figure 5: QUEST MCO Baseline for Goal 4 ED HEDIS Measure

ED Visits per 1000MM

Year	ED Visits per 1000MM
2007	36.81
2008	37.85
2009	39.56
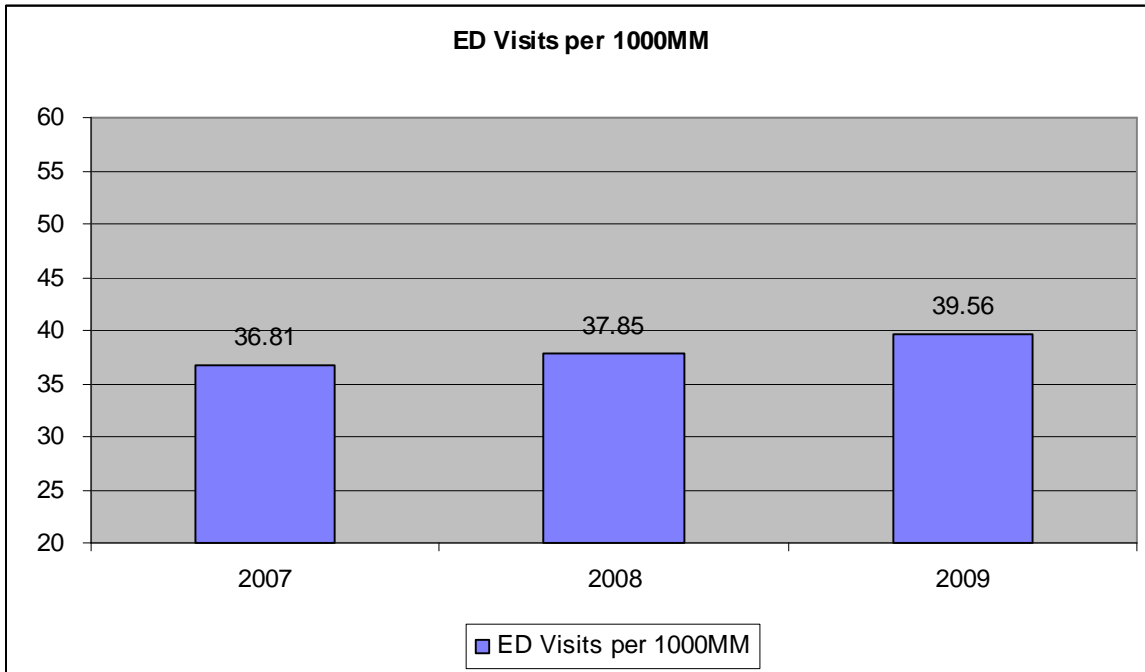
Goal 5: Monitor HCBS clients who have transitioned from waiver programs into QExA health plans.
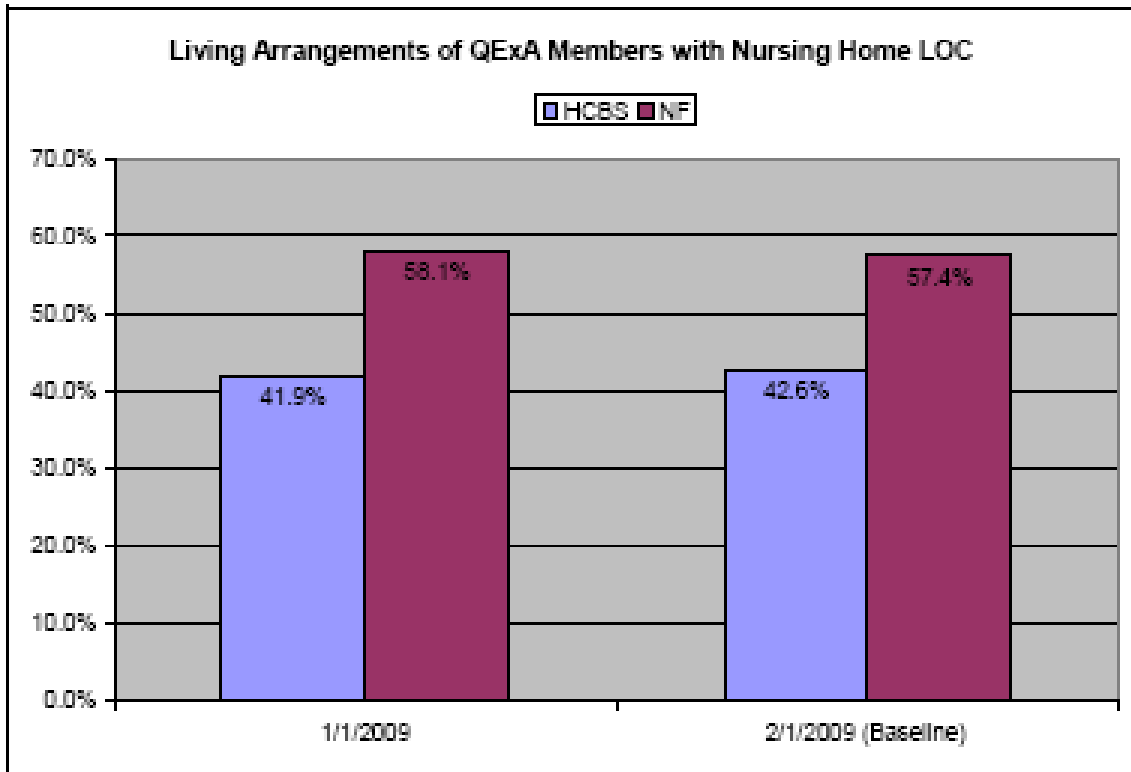
These set of objectives pertain to the QExA MCOs. Below are the data (Table 8 and Figure 6) that shows the baseline and first year data for clients receiving long-term care services in both HCBS and institutional settings. Examining ED visits and hospital admissions in HCBS clients are new measures, and baselines are still being established.

Table 8: QExA MCO Baseline on Nursing Facility and HCBS Clients

Living Arrangement	(1/1/09)	
	Number of clients	% of clients
Home or Community Based Services (HCBS)	2,065	41.9%
Nursing Facilities (NF)	2,862	58.1%
Total	4,954	100.0%
	Baseline (2/1/09)	
	Number of clients	% of clients
Home or Community Based Services (HCBS)	2,110	42.6%
Nursing Facilities (NF)	2,840	57.4%
Total	4,954	100.0%

Figure 6: QExA MCO Baseline on Nursing Facility and HCBS Clients

Living Arrangements of QExA Members with Nursing Home LOC

HCBS / NF

- 1/1/2009: HCBS 41.9%, NF 58.1%
- 2/1/2009 (Baseline): HCBS 42.6%, NF 57.4%

IV. QUALITY STRATEGY REVIEW AND EFFECTIVENESS

PROCESS AND TIMELINE OF QUALITY STRATEGY REVIEW

The Quality Strategy will be reviewed at least annually by the QSLT and revised based on analyses results. However, the QSCs may suggest changes to the QSLT throughout the year that will be reviewed to identify whether a suggested change necessitates a review and revision of the quality strategy sooner than the appointed time. At each review and revision of the strategy, the QSLT will determine whether the changes made to the Quality Strategy are significant enough to require additional stakeholder input and a public comment period. Significant changes are changes that significantly impact quality activities and/or threaten the potential effectiveness of the Quality Strategy. At least once every 5 years, unless significant changes dictate a sooner timeframe, a 30-day public comment period will be made available.

In subsequent years, a yearly Work Plan will be written to supplement the Quality Strategy during the annual review and revision process. The development of the Work Plan begins with an assessment of accomplishments and challenges from the previous year's Work Plan, the EQR technical report, and summary reports/input

from the QSCs. The Work Plan development also incorporates input from other sources such as MCOs, clients, providers, partner government agencies, and stakeholders. The Work Plan will clearly document the effectiveness of the Quality Strategy by summarizing successes and challenges as well as interim performance results for each strategy objective. The Work Plan also outlines areas of focus for quality activities, such as quality improvement measures, improvement projects, and performance indicators.

REPORTING REQUIREMENTS

The MCOs are held to a strict reporting calendar. Reports can be required monthly, quarterly, bi-annually, or annually, based on the type of report. See **Attachments 4 and 5** for further details. The analyses of these reports, as outlined in previous sections of this strategy, are an important basis of the yearly Quality Strategy revision and/or Work Plan development.

The revised Quality Strategy and the supplemental Work Plan will be shared with CMS annually. In addition, already established quarterly reports to CMS are headed by the MQD/HCSB staff and include updates on quality initiatives as well as Quality Strategy implementation and changes. The quarterly report also gives information on quantifiable achievements, data analyses, variation from expected results, barriers, interventions, best practices, and systems changes.

V. ACHIEVEMENTS AND OPPORTUNITIES

ACHIEVEMENTS

Drafting the Quality Strategy has allowed MQD to think strategically about the flow of quality data and the management of intervention activities. This is the first time that MQD has a cohesive Quality Strategy that can guide monitoring and intervention activities for all MCOs and programs. The plan to use QSCs to regularly guide reviewers and recommend corrective action/follow-up as well as the QSLT as a central team to which all quality activities are funneled will be an important step to ensuring the implementation of quality activities.

MQD continues to promote and support ongoing efforts of transparency and sharing among MCOs. There has also been significant improvement in the collaboration between MQD and the MCOs as well as between MQD and other programs (specifically the DD/MR waiver) on quality activities. The plan to institute formal Quality Collaboratives on a regular basis will strengthen these collaborations and assure a forum for dialogue, review of interim results, follow-up of corrective action, sharing of best practices, and identification of systems changes.

In addition to improved collaboration with the MCOs and other programs, there have also been ongoing partnerships with partner government agencies and stakeholder groups. These groups include DOH Chronic Disease branches, Tobacco Program, and Early Intervention Program, the American Academy of Pediatricians- Hawaii Chapter, Child Protective Services, the Nutrition and Physical Activity Coalition, among others. Projects have included improved education of providers and clients, better coordination of care for MCO clients, and development of policies and guidelines with local stakeholder input and support.

Also for the first time, public reporting and financial incentives/disincentives are being implemented. These activities support measures specific to MQD goals and objectives.

CHALLENGES AND FUTURE PLANS

Since this Quality Strategy is in the beginning stages of development and implementation, there will be modifications to the process at various steps of implementation. It will be important to continuously assess and revise the quality process to ensure the successful implementation of the Quality Strategy. In addition, performance measures and targets will also need to be continuously evaluated to ensure that the measures meet appropriate populations and domains of care. Plans for the future include the establishment of performance measures and improvement activities for Inpatient Hospitals, Long-term Care, and Mental Health.

MQD has been scattered in previous quality activities, with each branch or program implementing its own quality activities and forming silos within MQD. The Quality Strategy will focus quality activities for the whole division, informed from analyses of previous performance data and input from a variety of sources, breaking down barriers to promote quality efforts within MQD.

In the past, monitoring reports and performance measures have been reviewed but not acted upon. As a result, sustained improvement was not brought forth by corrective action, and systems changes were not identified. With the Quality Strategy, the hope is to be able to ensure the implementation of quality improvement process from reporting to systems improvement.