QUEST Integration
Quality Strategy

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Med-QUEST Division

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HAWAII QUEST INTEGRATION QUALITY STRATEGY 2015

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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. MQD will amend the Quality Strategy 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 beneficiaries conform to professionally recognized standards of practice and code of ethics;
- Identifying and pursuing opportunities for improvements in health outcomes, accessibility, efficiency, beneficiary 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 beneficiaries receive high quality care by collaborating with managed care plans, providers, and the community to seek innovative ways to promote health, and provide 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 beneficiaries 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 an individual's 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.

This framework can be summarized in the Three-Part Aim of "Better Health, Better Care, Lower costs." In addition, MQD recognizes that much of "health" is beyond the clinic walls related to the social determinants of health. MQD is also focused on working with the larger community in improving health by focusing on healthy communities and healthy families.

GUIDING PRINCIPLES

The MQD's quality approach aspires to the following:

Collaborative Partnerships

In Hawaii, the same providers deliver healthcare to patients who have public or private health insurance. Improving the quality of healthcare for Medicaid beneficiaries means improving the care for all Hawaii residents and requires collaboration among state agencies, 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. Most 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, early screening and intervention and integration of behavioral health.

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. MQD communicates this information 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, MQD has quality information posted on our website.

Data Driven

MQD's Data Warehouse allows MQD to perform analysis on encounter/claims data related to eligibility and enrollment data. This information allows specific measurement and analysis. In addition, MQD receives data compilation from external

sources to include but not limited to its health plans, External Quality Review Organization (EQRO), and actuaries.

Value/Quality Based Purchasing

The MQD incentivizes the provision of care that improves health outcomes. MQD uses non-financial incentives that include MCO report cards, Dashboards, and public reporting. Financial incentives include increased payment to MCOs for high quality care. In addition, MQD uses quality-based auto-assign algorithms to health plan enrollment.

HISTORY OF MANAGED CARE

Hawaii's statewide comprehensive 1115(a) demonstration waiver began on August 1, 1994 with the QUEST program, that 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, MQD converted medical assistance coverage for the population age 65 or older and disabled of all ages from fee-for-service (FFS) to managed care through the QUEST Expanded Access (QExA) program. Adults and children eligible for Medicaid received their healthcare through QUEST and QExA. Children and pregnant women eligible for the State Children's Health Insurance Program (SCHIP) were also enrolled in the QUEST program and receive the same benefits as QUEST members.

Beneficiaries 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 Developmental Disabilities/Intellectual Disabilities (DD/ID) 1915(c) waiver remains as a waiver program, providing services jointly with the QExA MCOs.

On January 1, 2015, the MQD combined its QUEST and QExA programs into one program called QUEST Integration (QI). The QUEST Integration program has five (5) health plans. The goals for the QUEST Integration program are:

- Improve the health care status of the member population;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Align the demonstration with Affordable Care Act;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP);

- Expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS; • Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations;
- Establish contractual accountability among the contracted health plans and health care providers; • Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

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 beneficiaries 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 beneficiaries 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 beneficiaries 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. In addition, MQD incorporates input from the External Quality Review Organization (EQRO), partner government agencies (e.g. Department of Health), providers, beneficiaries, 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 beneficiary 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.

Beneficiary and Provider Input

Beneficiary and provider input most directly occur through the results of beneficiary and provider surveys that the EQRO administers and reports. In addition, MCOs submit information on Member Grievance and Appeals Reports as well as Provider Complaints Reports and guides our Quality Strategy. Finally, MQD conducts public forums to gather input from beneficiaries, providers, and other stakeholders.

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

MQD will obtain public input 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/ID 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/ID waiver, the Community Care Services (CCS) program (MQD's behavioral health program), the State of Hawaii Organ and Tissue Transplant (SHOTT) program, and the EQRO. The HCSB uses standardized reporting and review tools 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 recommend feedback to the MCOs and programs, and corrective action will be requested if needed. Findings and recommendations are 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:

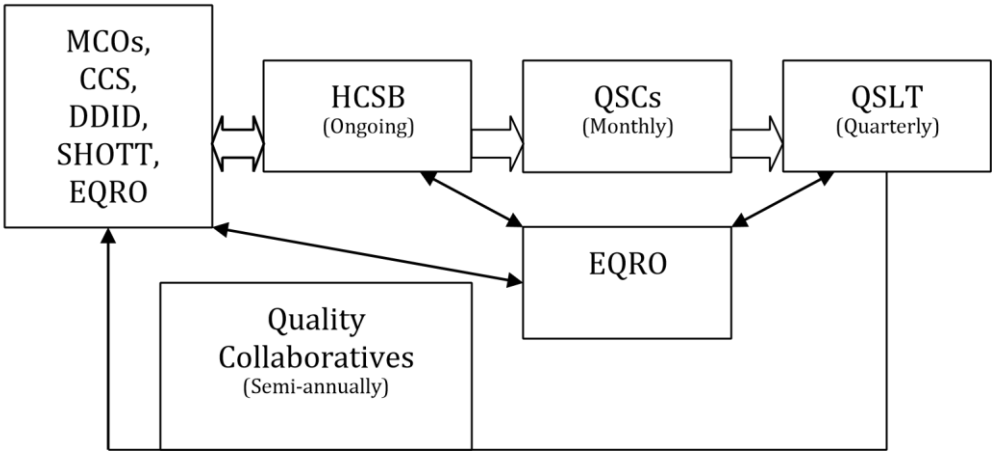


Table 1: Summary of the Quality Strategy Oversight:

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
Entities	**Membership**	**Responsibilities**
		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 Integration compliance, QUEST Integration 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 beneficiaries 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. The chart below identifies the Medicaid populations that each goal in the quality strategy addresses.

Table 3: Performance measures by Medicaid populations

Goal	Children under 19 years of age	Former foster care children under 26 years of age	Pregnant Women	Parent or Caretaker Relatives	Adults (19 to 64 years of age)	Aged, Blind, or with a Disability (includes dual eligible individuals)

Improve preventative care for women and children	X	X	X	X	X	X
Improve healthcare for individuals who have chronic illnesses	X	X	X	X	X	X
Improve beneficiary satisfaction with health plan services	X	X	X	X	X	X
Improve costefficiency of health plan services	X	X	X	X	X	X
Expand access to Home and Community Based Service (HCBS) and assure that individuals have a choice of institutional and HCBS	X	X	X	X	X	X
Improve access to community living and the opportunity to receive services in the						X
Goal	Children under 19 years of age	Former foster care children under 26 years of age	Pregnant Women	Parent or Caretaker Relatives	Adults (19 to 64 years of age)	Aged, Blind, or with a Disability (includes dual eligible individuals)
most integrated setting appropriate for individuals receiving HCBS						

Goal 1: Improve preventive care for women and children Objectives:

- Childhood Immunizations: For calendar year 2015 (HEDIS 2016) data, increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the 2015 Medicaid 75th percentile.
  - Frequency of Ongoing Prenatal Care: For calendar year 2015 (HEDIS 2016) data, increase performance on the state aggregate HEDIS Frequency of Ongoing Prenatal Care measure to meet/exceed the 2015 Medicaid 75th percentile.
- Timeliness of Prenatal Care: For calendar year 2015 (HEDIS 2016) data, increase performance on the state aggregate HEDIS Timeliness of Prenatal Care measure to meet/exceed the 2015 Medicaid 75th percentile.
- Breast Cancer Screening: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the 2015 Medicaid 75th percentile.
- Cervical Cancer Screening: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Cervical Cancer Screening measure to meet/exceed the 2015 Medicaid 75th percentile. • Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services: For federal fiscal year 15, increase participant ratio on the state aggregate Participant Ratio to meet/exceed 80 percent for children of all ages.

Goal 2: Improve healthcare for individuals who have chronic illnesses
Objectives:

- Comprehensive Diabetes Care Measures:
  ○ For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the 2015 HEDIS 75th percentile. ○ For calendar year 2015 (HEDIS 2016), improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (>9) to meet/exceed the 2015 HEDIS 50th percentile. ○ For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<8) to meet/exceed below the 2015 HEDIS 50th percentile. ○ For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<140/90) to meet/exceed the 2015 HEDIS 75th percentile. ○ For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS

Diabetes Care Measure for eye exams to meet/exceed the 2015 HEDIS 75th percentile.

- Blood Pressure Control in the General Population: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the 2015 HEDIS 75th percentile.
- Appropriate Medications in Asthma: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the 2015 HEDIS 75th percentile.
- Reduce the percent of asthma related Emergency Department visits for Medicaid beneficiaries ages 0 to 20: For calendar year 2015, decrease the percent of asthma related Emergency Department visits to less than or equal to 6%.

Goal 3: Improve beneficiary satisfaction with health plan services Objectives:

- For calendar year 2015, increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile.
- For calendar year 2015, increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile.
- For calendar year 2015, increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile.

Goal 4: Improve cost-efficiency of health plan services Objectives:

- Monitor Plan All Cause Readmission annually to identify if improving from baseline that was established in calendar year 2013. MCOs will perform Performance Improvement Programs (PIPs) on Plan All Cause Readmission to improve this measure.
- Follow-Up After Hospitalization for Mental Illness: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Follow-Up After Hospitalization for Mental Illness measure to meet/exceed the 2015 HEDIS 75th percentile.
- Medication Reconciliation Post-Discharge: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate Medication Reconciliation Post Discharge measure to meet/exceed the 2015 HEDIS 75th percentile.

- Improve performance on the state aggregate for calendar year 2015 (HEDIS 2016) Emergency Department Visits/1000 rate to meet/fall below the HEDIS 2015 10th percentile.

Goal 5: Expand access to Home and Community Based Service (HCBS) and assure that individuals have a choice of institutional and HCBS Objectives:

- Increase the proportion of beneficiaries receiving HCBS instead of institutional-based long-term care services by 5% over the waiver demonstration (to 70%).

Goal 6: Improve access to community living and the opportunity to receive services in the most integrated setting appropriate for individuals receiving HCBS Objectives:

- Assure that settings are integrated and support full access to the greater community by each setting meeting/exceeding 85% compliance with the HCBS final rules.
- Optimize individuals' initiative, autonomy and independence in making life choices (including daily activities, physical environment, and with whom to interact) by beneficiaries confirming their setting meets/exceeds 85% compliance with the HCBS final rules.

In the upcoming year, additional goals focused on the Integration of Behavioral Health, and supporting Healthy Communities/Healthy Families will be developed.

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 beneficiary's race, ethnicity, and primary language. Either the eligibility worker or the applicant (through their Medicaid application) enters primary language (both

verbal and written) information into the Department of Human Services Kau'hale OnLine Eligibility Assistance (KOLEA) eligibility system. The information is 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 beneficiaries receiving Supplemental Security Income.

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

Table 4: Primary Language Codes

Languages Obtained			
AR	Arabic	MA	Malay
AM	Aramaic	ML	Maltese
BE	Bengali	MO	Maori
BI	Bisayan	MR	Marquesan
BU	Bulgarian	MS	Marshallese
CE	Cebuano	MK	Mon-Khmer
CH	Chamorro	NA	Navaho
CU	Chuukese	NO	Norwegian
CZ	Czech	OA	Other Asian
DA	Danish	OI	Other Indo-European
DU	Dutch	ON	Other North American Indian
ES	Estonian	PW	Paiwan
FJ	Fijian	PP	Papuan
FN	Finnish	PE	Persian
FM	Formosan	PO	Pohnpeian
FR	French	PL	Polish
FC	French Creole	PR	Portuguese

GE	German	RA	Rapanui
GR	Greek	RO	Romanian
GU	Gujarathi	RU	Russian
HE	Hebrew	SE	Serbian
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 beneficiaries 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 3year 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; 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 submits 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. MQD sends copies of the technical reports to CMS.

The EQR results and technical reports are 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 provides 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 two (2) clinical practice 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

The MQD has identified a set of performance measures and PIP topics that address a range of priority issues for Medicaid beneficiaries. 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. Beneficiary and provider input, through results of beneficiary 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.

The MQD favors measures whose results can be compared to national standards, and this is why we primarily report HEDIS and CAHPS measures. The MQD ensures that any HEDIS and CAHPS measures that are a part of the Child Core Set and Adult Core Set are included as a performance measures here in the Quality Strategy, and are also reported to CMS via the CARTS process.

Table 5: Selected HEDIS Performance Measures for 2015

	Non-Aged, Blind, Disabled (Non-ABD) HEDIS 2015 Measures		
I	**Effectiveness of Care**		HYBRID or ADMIN
	Adult BMI Assessment	ABA	H
	Childhood Immunization Status	CIS	H
	Immunization for Adolescents	IMA	H
	Human Papillomavirus Vaccine for Female Adolescents	HPV	H
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Counseling for	WCC	H
	Breast Cancer Screening	BCS	A
	Cervical Cancer Screening	CCS	H
	Colorectal Cancer Screening	COL	H
	Chlamydia Screening in Women	CHL	A
	Pharmacotherapy Management of COPD Exacerbation	PCE	A
	Use of Appropriate Medications for People with Asthma	ASM	A
	Medication Management for People with Asthma	MMA	A
	Controlling High Blood Pressure	CBP	H
	Persistence of B Blocker Treatment after a Heart Attack	PBH	A
	Comprehensive Diabetes Care	CDC	H
	Hemoglobin A1c (HbA1c) Tested		H
	HbA1c Poor Control (>9%)		H
	HbA1c Control (<8%)		H
	HbA1c Control (<7%)		H
	Eye Exam (Retinal) Performed		H
	Medical Attention for Nephropathy		H
	Systolic and Diastolic BP Levels < 140 / 90		H
	Antidepressant Medication Management	AMM	A
	Adherence to Antipsychotics for Individuals with Schizophrenia	SAA	A
	Follow-Up of Care for Children Prescribed ADHD Medication	ADD	A
	Follow-Up After Hospitalization for Mental Illness	FUH	A
	Annual Monitoring for Patients on Persistent Medications	MPM	A
II	**Access/Availability of Care**		
	Frequency of Ongoing Prenatal Care	FPC	H
	Adults' Access to Preventive/Ambulatory Health Services	AAP	A
	Children & Adolescents' Access to Primary Care Practitioners	CAP	A
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET	A
	Prenatal and Postpartum Care	PPC	H
	Timeliness of Prenatal Care		
	Postpartum Care		
III	**Use of Services**		
	Well-Child Visits in the First 15 Months of Life	W15	H
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	W34	H
	Adolescent Well-Care Visits	AWC	H
	Inpatient Utilization -- General Hospital/Acute Care	IPUA	A
	Ambulatory Care	AMBA	A
	Mental Health Utilization	MPTA	A
	Plan All-Cause Re-Admissions (report applying the Commercial weighting tables)	PCR	A
IV	**Health Plan Descriptive Information**		
	Enrollment by Product Line	ENP	A

	Aged, Blind, Disabled (ABD) HEDIS 2015 Measures		
I	**Effectiveness of Care**		or ADMIN
	Adult BMI Assessment	ABA	H
	Childhood Immunization Status	CIS	H
	Immunization for Adolescents	IMA	H
	Human Papillomavirus Vaccine for Female Adolescents	HPV	H
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Counseling for	WCC	H
	Breast Cancer Screening	BCS	A
	Cervical Cancer Screening	CCS	H
	Colorectal Cancer Screening	COL	H
	Chlamydia Screening in Women	CHL	A
	Care for Older Adults	COA	H
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	SPR	A
	Pharmacotherapy Management of COPD Exacerbation	PCE	A
	Use of Appropriate Medications for People with Asthma	ASM	A
	Medication Management for People with Asthma	MMA	A
	Controlling High Blood Pressure	CBP	H
	Persistence of B Blocker Treatment after a Heart Attack	PBH	A
	Comprehensive Diabetes Care	CDC	H
	Hemoglobin A1c (HbA1c) Tested		H
	HbA1c Poor Control (>9%)		H
	HbA1c Control (<8%)		H
	HbA1c Control (<7%)		H
	Eye Exam (Retinal) Performed		H
	Medical Attention for Nephropathy		H
	Systolic and Diastolic BP Levels < 140 / 90		H
	Antidepressant Medication Management	AMM	A
	Adherence to Antipsychotics for Individuals with Schizophrenia	SAA	A
	Follow-Up of Care for Children Prescribed ADHD Medication	ADD	A
	Follow-Up After Hospitalization for Mental Illness	FUH	A
	Annual Monitoring for Patients on Persistent Medications	MPM	A
	Medication Reconciliation Post-Discharge	MRP	H
II	**Access/Availability of Care**		
	Frequency of Ongoing Prenatal Care	FPC	H
	Adults' Access to Preventive/Ambulatory Health Services	AAP	A
	Children & Adolescents' Access to Primary Care Practitioners	CAP	A
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET	A
	Prenatal and Postpartum Care	PPC	H
	Timeliness of Prenatal Care		
	Postpartum Care		
III	**Use of Services**		
	Well-Child Visits in the First 15 Months of Life	W15	H
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	W34	H
	Adolescent Well-Care Visits	AWC	H
	Inpatient Utilization -- General Hospital/Acute Care	IPUA	A
	Ambulatory Care	AMBA	A
	Mental Health Utilization	MPTA	A
	Plan All-Cause Re-Admissions (report applying the Medicare weighting tables)	PCR	A
IV	**Health Plan Descriptive Information**		
	Enrollment by Product Line	ENP	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. A link to the QUEST Integration contract (Request for Proposals link) can be found on the MQD website at http://www.medquest.us/Quest/QuestIntegration.html. 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, Long-Term Services and Supports, Special Health Care Needs, among others. Individuals with Special Health Care Needs are: • Individuals under twenty-one (21) years of age who have a chronic physical, developmental, behavioral, or emotional condition and who requires health and related services of a type or amount beyond that generally required by children;

- Individuals who are twenty-one (21) years of age or older and have chronic physical, behavioral, or social conditions that requires health related services of a type or amount beyond that required by adults generally; and • Individuals of any age that are receiving long-term services and supports (both institutional and home and community based services (HCBS)).

MQD issues reporting calendars annually to the MCOs. The DD/ID program also has required reporting based upon their 1915(c) waiver that is in compliance with CMS HCBS Quality Framework.

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. The MQD posts the EQRO technical report annually on its website (www.med-quest.us) under the CMS Reports section.

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. The EQRO validates all of the HEDIS measures 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. The MQD chooses PIP topics (in collaboration with?....) to meet goals identified in this quality strategy. All QUEST Integration health plans participate in the same PIP topics to assure a greater impact on that population.

Public Summary Report: The MQD developed a public summary report that compiles health plan data on their overall performance. This document reports information in an easy to follow format that includes normalized data presented in both numbers and charts for ease of understanding. MQD obtained public input into the report format in June/July 2015. MQD designed this report to promote transparency with the daily functioning of the QI health plans. MQD will start posting this quarterly report on its website in September 2015.

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	Public Summary Report	Encounter Data
Frequency	Various Timeframes	Annual	At least once in 3 years	Annual	Every other year	Annual	Annual and Ongoing	Quarterly	Ongoing
Access to Care Standards									
Availability of Services	X	X	X	X					X
Delivery of Network Adequacy	X	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		X	
Coverage and Authorization of Services	X	X	X	X	X			X	
Emergency and Post Stabilization Services		X	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					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
HCBS Quality Framework	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 beneficiaries and therefore does not apply to our contracted MCOs.

Hawaii Revised Statute 432E-11 requires that managed care plans doing business in Hawaii are accredited by a national accrediting organization. The requirement for QUEST Integration is that National Committee accredits all health plans for Quality Assurance (NCQA).

The MQD implemented the non-duplication strategy for credentialing and recredentialing. However, MQD has chosen to require its EQRO to complete the credentialing and re-credentialing portion of compliance review going forward. MQD finds that with the implementation of the Affordable Care Act (ACA) requirements for provider enrollment, these functions are critical for provider oversight. In sum, going forward the MQD will not be using non-duplication for credentialing, re-credentialing, or other EQRO activities.

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.

Accuracy and Completeness – DHS will measure accuracy with the following measures: o Pended Rate for the latest month and the cumulative average for the past three (3) and six (6) months that is calculated based on new system pends for each encounter submission divided by the total encounter lines in that submission.

- Twelve (12) months new pends that is calculated based upon the last twelve month pended errors divided by total encounter lines (including resubmitted adjusted, void and denied encounters).
- Total Pended Rate that is calculated based on cumulative total pended errors divided by the sum of the total encounter lines in the past twelve (12) months' submissions.

The following accuracy targets apply:

- Current Pended Rate of less than five percent (5%);
- Current Pended Rate of less than five percent (5%) for cumulative averages for the past three (3) and six (6) months; and
- Cumulative twelve month pended rate less than ten percent (10%); and ○ Cumulative Total Pended Rate of twenty-five percent (25%).

Timeliness – Sixty percent (60%) of the encounter data shall be received by the DHS no more than one-hundred twenty (120) days from the date that services were rendered. Health plans shall have the goal of submitting one-hundred percent (100%) and shall submit no less than ninety-nine percent (99%) of encounter data within fifteen (15) months from the date of services. Adjustments and resubmitted encounters shall not be subject to the one-hundred twenty (120) day submission requirement. In addition, TPL related encounters shall not be subject to the one-hundred twenty (120) day submission deadline.

MQD may 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 Integration 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.

MQD uses information from HPMMIS 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 also enhances efforts in quality improvement as it enables MQD to monitor HEDIS-like quality and utilization measures for specific populations (HCBS beneficiaries, DD/ID participants, beneficiaries over the age of 65, among others) outside of MCO annual HEDIS reporting. Through the Data Warehouse, the MQD can also monitor utilization and cost-efficiency.

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. MQD, DOH and the Department of Education are also regularly discussing the best ways to improve the collaboration of state agencies to better ensure access to and the quality of health services provided to children, regardless of where they are.

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 Integration MCOs. There are also regular medical director meetings that bring together the MQD medical director with the medical directors of the QUEST Integration MCOs. Sharing of common problems, monitoring activities, and performance measures occur in these meetings, and these collaborations result in the sharing 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.

The EQRO will validate all HEDIS measures in 2015. The EQRO requires corrective action for lack of improvement. In addition, MQD uses performance measures for the following quality activities:

- QUEST Integration consumer guide;
- Financial incentives for improved MCO performance; and
- Quality factors for portion of auto-assign.

During review and discussion of performance measures at the QSCs and QSLT meetings, opportunities are sought to implement cross- organizational and interagency 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. The current mandatory PIP topics for the QUEST Integration MCOs are Plan All Cause Readmission and Diabetes Self-Management.

The EQRO's new rapid-cycle PIP approach represents a modified version of the

Institute for Healthcare Improvement's (IHI's) Quality Improvement (QI) Model for Improvement. Key concepts include the formation of a team, setting aims, establishing measures, selecting interventions, testing interventions, implementing interventions, and spreading changes. The IHI model focuses on accelerating improvement without replacing change models that different organizations may already be using. The core component of the model includes testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation that informs the project theory during the course of the improvement project.

The EQRO selected this framework as it allows broad flexibility for different health plans, builds upon proven quality concepts, and provides a systematic way to approach an improvement activity. This new framework for PIPs includes five Modules:

Module 1: PIP Initiation
Module 2: SMART Aim and Baseline Data Collection Module
3: Intervention Determination
Module 4: Intervention Testing
Module 5: PIP Conclusions

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 has a public reporting mechanism, which includes a variety of performance measures, displayed by MCO, in a simple and understandable 'consumer guide'. This guide allows a comparison of the MCOs across a variety of measures and can be distributed to beneficiaries, providers, and stakeholders. In addition, MQD provides information on a Dashboard that identifies providers, claims paid, grievance, appeals, utilization, and other factors.

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.

PROGRESS TOWARDS OBJECTIVES

Efforts are ongoing to promote transparency and sharing of best practices among the QUEST Integration 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. Public reporting and financial incentives are included in the QUEST Integration MCOs contract and it is expected that future results for these measures will improve. MQD posts information submitted to CMS on quality on its website at http://www.medquest.us/ManagedCare/CmsReport.html.

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 HEDIS 2014.

Table 7: QUEST MCO Baseline for Goal 1 Objectives

HEDIS Measures	HEDIS 2014/other	Comment
Childhood Immunizations—Combo 2	76.08	
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	9.44	
Frequency of Ongoing Prenatal Care (81–100% of Visits)	52.89	
Timeliness of Prenatal Care	75.83	
Breast Cancer Screening	84.99	
Cervical Cancer Screening	69.67	No National Medicaid benchmark
EPSDT- Participant Ratio	0.78	No National Medicaid benchmark

Legend:

	National Medicaid HEDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Goal 2: Improve care for chronic illness

For the measures under Goal 2, there is baseline data for the QUEST MCOs who have been submitting HEDIS data to MQD. The figure below shows data from HEDIS 2014.

Table 8: QUEST MCO Baseline for Goal 2 Objectives

HEDIS Measures	HEDIS 2014/other	Comment
Comprehensive Diabetes Care		
HgbA1c Testing	84.99	
HgbA1c Control (>9)	49.57	
HgbA1c Control (<8)	40.34	
Blood Pressure Control (<140/90)	58.28	
Retinal Screening	59.02	
Other Measures		
Controlling High Blood Pressure (<140/90)	55.86	
Appropriate Medication for Asthma- Total	79.63	
Asthma related ED visits- CY2013	7.2	No National Medicaid benchmark

Legend:

	National Medicaid H EDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

3: Improve beneficiary satisfaction with health plan services

The measures for beneficiary satisfaction come from the CAHPS survey, administered for adults and children in alternate years. Below is the baseline for 2014 CAHPS.

Table 9: QUEST MCO 2014 Baseline for Goal 3 Satisfaction Measures

Getting Needed Care	75.8	

Rating of Health Plan	56.2	
How Well Doctors Communicate	90.3	Above NCQA National Medicaid Average

Goal 4: Improve cost-efficiency of health plan services

For the measures under Goal 4, MQD will establish baseline data with HEDIS 2015.

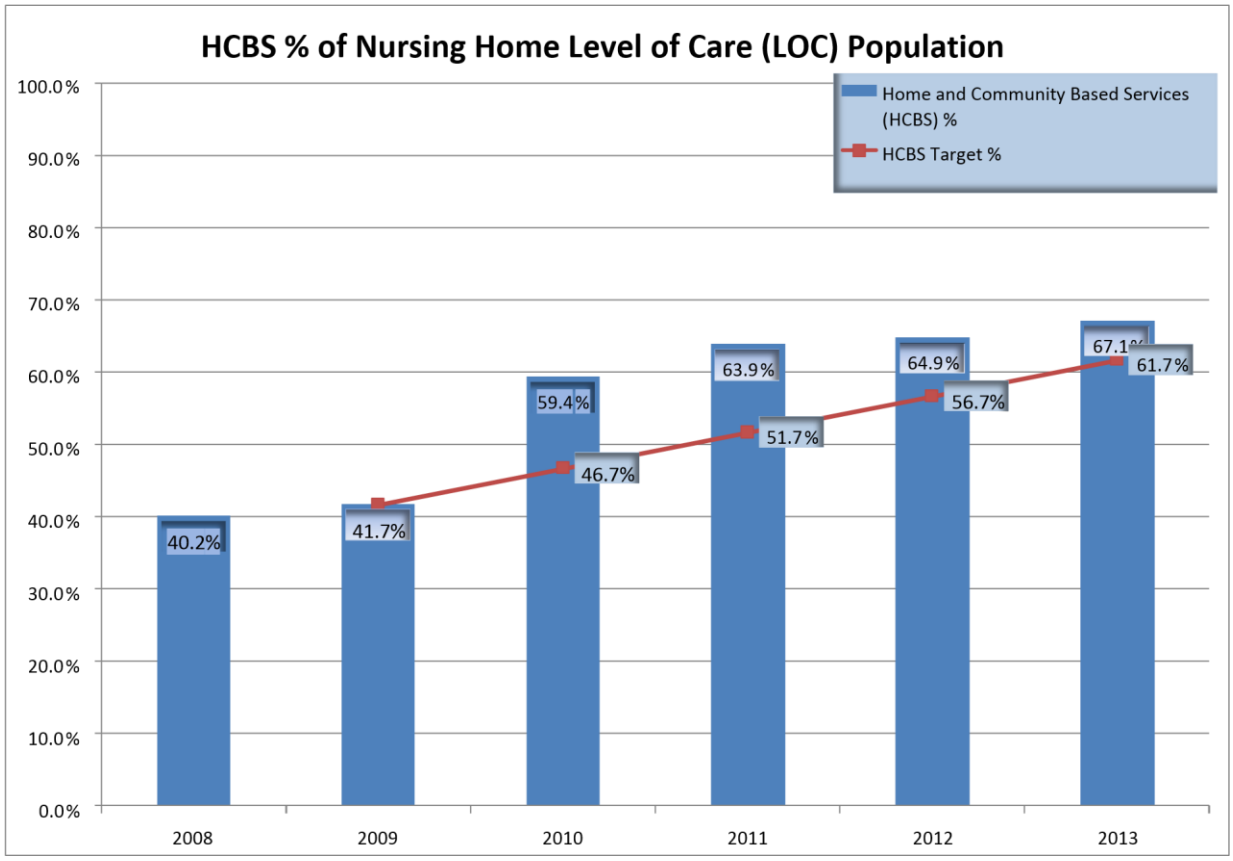
Goal 5: Expand access to HCBS and assure that individuals have a choice of instructional or HCBS

Below is a chart that identifies baseline data when MQD moved its ABD population into managed care. In addition, we have provided a graph that show growth of HCBS from 2008 to 2013. MQD intends to continue to expand this growth (though not as aggressively as it has done previously).

Table 10: MCO Baseline on Nursing Facility and HCBS Beneficiaries

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 2: Growth of HCBS for LOC Population



Goal 6: Improve access to community living and the opportunity to receive services in the most integrated setting appropriate for individuals receiving HCBS.

For the measures under Goal 6, MQD will establish baseline data with surveys conducted in April to June 2015. Annually, MQD will perform surveys to measure progress on meeting this goal.

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. Examples of a significant change include but are not limited to placing limits

on benefits, adding new categories of benefits not previously offered, or major changes to regulations that the quality strategy is based on. 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, beneficiaries, 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. 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 beneficiaries, better coordination of care for MCO beneficiaries, and development of policies and guidelines with local stakeholder input and support.

MQD will continue to report publically and use quality data for financial incentives.

CHALLENGES AND FUTURE PLANS

It is 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 and Long-term Care.

MQD has improved through the use of its past quality strategy to organize quality, compile data, and use it to make improvement in its programs. MQD intends to continue with these processes going forward.

This quality strategy incorporates MQD's current quality objectives. However, the MQD will submit a revised quality strategy to Centers for Medicare & Medicaid Services (CMS) to incorporate any changes required by revised managed care final rules. In addition, MQD will continue to adapt its quality program as Hawaii undergoes healthcare transformation.