

Summaries of EQRO Reports and Quality Assurance Monitoring, and Other Information and Documentation Regarding Quality of and Access to Care

DHS contracted with the Health Services Advisory Group, Inc. (HSAG) as its external quality review organization (EQRO) to monitor QUEST Expanded’s managed care health plans. The 2012, 2011, and 2010 External Quality Review Reports of Results for the QUEST and QExA Health Plans (hereafter “EQR Reports”), which provide detail about the EQRO’s activities, are available at <http://www.med-quest.us/ManagedCare/consumerguides.html>.

In 2012, HSAG performed the three federally mandated activities as set forth in 42 C.F.R. § 438.358—a follow-up review and evaluation of compliance with select federal managed care standards and associated State contract requirements, validation of performance measures/Healthcare Effectiveness Data and Information Set (HEDIS®) compliance audits, and validation of performance improvement projects (PIP). One optional EQR activity was also performed this year: a survey of adult members using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

External Quality Review Activity	Description	Findings, Conclusions, and/or Recommendations
<p>Follow-up Review and Evaluation of Compliance with Federal Managed Care Standards and State Contract Requirements</p>	<p>In 2011, the plans received individual scores for each of the five areas reviewed for compliance. These five areas were related to the health plans’ structure and operations, as described in the managed care regulations at 42 C.F.R. §§ 438.214-230. These scores can be viewed in the 2011 EQR Report at the link cited above. Following issuance of the final reports, the health plans were required by the MQD to submit corrective action plans (“CAP”) for any standards scored “Partially Met” or “Not Met.”</p> <p>For the 2012 re-evaluation of health plan compliance, HSAG used a monitoring tool to assess and document the health plans’ implementation of CAPs in any standards where deficiencies had been identified during the 2011 review.</p>	<p>Following completion of their CAPs, each plan submitted documentation for HSAG’s desk review and participated in an onsite and/or telephonic re-evaluation to ensure that the deficiencies were resolved and that compliance was attained. As needed, health plans were provided additional technical assistance and monitoring until demonstrating compliance with each standard. The results of each re-evaluation were provided to the plan and the MQD as a record of how the deficiencies were addressed.</p> <p>In the end, all health plans achieved full compliance with the standards during this calendar year: all 136 CAPS required as a result of the 2011 scores were “closed” and found compliant during the follow up review this year.</p> <p>More detail about these CAP closures can be found in the 2012 EQR Report at the link cited above.</p>

<p>Validation of Performance Measures/HEDIS®</p>	<p>HSAG performed independent audits of the HEDIS data for the QUEST and QExA health plans. Each HEDIS Compliance Audit incorporated a detailed assessment of the health plans’ information systems capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures.</p> <p>During the HEDIS audits, HSAG reviewed the performance of the health plans on State-selected HEDIS performance measures. The six measures reviewed for the QUEST health plans were: Childhood Immunization Status, Well-Child Visits in the First 15 Months of Life, Controlling High Blood Pressure, Comprehensive Diabetes Care, Ambulatory Care, and Chlamydia Screening in Women. The six measures reviewed for the QExA health plans were: Cholesterol Management for Patients with Cardiovascular Conditions, Comprehensive Diabetes Care, Adults’ Access to Preventive/Ambulatory Health Services, Ambulatory Care, Inpatient Utilization—General Hospital/Acute Care, and Plan All-Cause Readmissions. The measurement period was calendar year 2011 and the audit activities were conducted concurrently with HEDIS 2012 reporting.</p>	<p>All plans were compliant with the National Committee for Quality Assurance’s (NCQA) information systems standards. Plans varied in how they compared to the HEDIS 2011 national Medicaid percentiles. Those comparisons can be viewed in the 2012 EQR Report at the link cited above. Recommendations varied across the indicators. HSAG recommended that each plan target the lower-performing measures for improvement.</p>
<p>Validation of Performance Improvement Projects</p>	<p>Performance Improvement Projects (PIP) are designed to assess health care processes, implement process improvements, and improve outcomes of care. In 2012, HSAG validated two PIPs for each of the QUEST and QExA health plans.</p> <p>The QUEST plans were required to conduct PIPs on Access to Care and a second topic to improve a HEDIS measure. The plans’ selected topics included childhood immunizations and controlling blood pressure.</p> <p>The QExA plans were required to conduct one PIP on improving the results of a HEDIS measure and a second PIP on a topic of the plan’s choice, approved by the MQD. Both QExA plans conducted PIPs related to the HEDIS measure on diabetes care. For their second PIP topic, both QExA plans focused on an aspect of obesity care.</p>	<p>HSAG validated each QUEST and QExA health plans’ PIPs by following standardized validation procedures, assessing the degree to which the projects were designed, conducted, and reported in a methodologically sound manner. This process facilitates improvements in care and generates confidence that reported improvement has, in fact, been accomplished.</p> <p>Following the review and validation of the health plans’ 2012 projects, HSAG arrived at a handful of specific conclusions, which can be viewed in the 2012 EQR Report at the link cited above.</p>
		<p>The results of nine measures of satisfaction were reported. These</p>

<p>CAHPS®</p>	<p>The CAHPS health plan surveys are standardized survey instruments that measure members' satisfaction levels with their health care. For 2012, HSAG administered the CAHPS 4.0H Adult Medicaid Health Plan Survey to members of the QUEST and QExA health plans over 18 years of age.</p>	<p>measures included four global ratings (<i>Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often</i>) and five composite measures (<i>Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making</i>).</p> <p>The QUEST health plans' aggregate score was above the NCQA national adult Medicaid average on six measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, How Well Doctors Communicate, and Shared Decision Making. The QExA health plans' aggregate score was above the NCQA national adult Medicaid average on one measure, Rating of Personal Doctor, and was within two percentage points of the national average on three other measures: How Well Doctor's Communicate, Rating of Specialist Seen Most Often, and Rating of All Health Care.</p> <p>More details about the CAHPS findings can be found in the 2012 EQR Report at the link cited above.</p>
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In 2010, the Med-QUEST Division finalized a new Quality Strategy in compliance with 42 C.F.R. § 438.202, which was approved by CMS. A copy of the Quality Strategy is available at <http://www.med-quest.us/ManagedCare/qualitystrategy.html>.

Under the Quality Strategy, the Med-Quest Division receives and reviews all monitoring and quality reports from the health plans, the Developmentally Disabled/ Intellectually Disabled 1915c waiver, the State of Hawaii Organ and Tissue Transplant program, and the EQRO. Findings from the reports are presented to various Quality Strategy Committees on a monthly rotation. The Committees are composed of representatives from the Quality Strategy Leadership Team, technical experts from the programs being reviewed, and other staff involved in contractual oversight and monitoring. 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 health plans and programs, and corrective action is requested if needed.

The Med-QUEST Division also began implementing CMS's Quality Framework for home and community-based services (HCBS) in state fiscal year 2011. The quality grid included measures

that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. The State will use this template for HCBS monitoring.

Like all States, Hawaii compiles data for the CMS-Form 416, Annual EPSDT Participation Report. Form 416 includes the number of individuals eligible for EPSDT, the number receiving screening, the number referred for medical treatment, and the number provided dental services. Hawaii's 2011 Form 416 shows a screening ratio of 98%, and a participation ratio of 78%. The Form 416s from 2010 and from 2011 will be included in the final application.