

*State of Hawaii  
Department of Human Services  
Med-QUEST Division  
601 Kamokila Boulevard, Room 518  
Kapolei, Hawaii, 96707*

# ***QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN***

## *Med-QUEST*

### *QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN*

#### **I. PURPOSE**

The purpose of the Quality Strategy Work Plan is to support the Strategy goals and objectives and describe an organized schedule of quality improvement (QI) activities during 2003–2004.

#### **II. SCOPE**

The scope of the Work Plan includes MCO and State activities related to ambulatory care, inpatient and outpatient hospital services, ancillary services, behavioral health and substance abuse services, home care, long term care, hospice services and administrative support services.

#### **III. POPULATION DEMOGRAPHICS**

The demographic and epidemiological data are the basis for selection of the Strategy activities and studies. As the population fluctuates and new information becomes available, the Work Plan will be updated to facilitate the health care needs of our recipients. The member count represents current knowledge as of June 30, 2002 and is based on the most recent HEDIS data reported by the MCOs. The Top Ten (10) diagnoses are based on encounter data submitted by the MCOs for the fiscal year July 1, 2002 through June 30, 2002. The most frequent diagnoses are listed from top to bottom in order of frequency.

**Unduplicated Member Count \***

Age	Sex	QUEST Plan	Age	Sex	QUEST Plan
<1	M	3,797	45-49	M	2,987
	F	3,591		F	3,206
1-4	M	13,102	50-54	M	2,041
	F	12,360		F	2,112
5-9	M	13,738	55-59	M	1,180
	F	13,181		F	1,509
10-14	M	12,107	60-64	M	809
	F	11,691		F	1,289
15-17	M	5,869			
	F	5,839	Subtotal:	M	7,017
18-19	M	3,083	45-64	F	8,116
	F	4,118		Total	15,133
Subtotal:	M	51,696	65-69	M	50
0-19	F	50,780		F	89
	Total	102,476	70-74	M	2
				F	2
20-24	M	4,691	75-79	M	-
	F	9,713		F	1
25-29	M	4,025	80-84	M	-
	F	7,283		F	-
30-34	M	3,820	85-89	M	-
	F	6,409		F	-
35-39	M	3,879	90 and over	M	-
	F	5,621		F	-
40-44	M	3,669			
	F	4,468	Subtotal:	M	52
			65 and over	F	92
Subtotal:	M	20,084		Total	144
20-44	F	33,494			
	Total	53,578	Age		
			Unknown		-
			<b>Total</b>		171,331

\* Addition of all plans' member counts. Some members were double-counted when they changed plans in the reporting state fiscal year.

## Top Ten Medicaid Managed Care Ambulatory Diagnoses 2002

ICD-9 Code	Diagnosis
465.**	Acute Upper Respiratory Infections of Multiple or Unspecified
*****	Prenatal
*****	Postpartum
382.**	Suppurative and Unspecified Otitis Media
493.**	Asthma
V 20.**	Health Supervision of Infant or Child
466.**	Acute Bronchitis and Bronchiolitis
780.**	General Symptoms
462.**	Acute Pharyngitis
250.**	Diabetes Mellitus

## Top Ten Medicaid Managed Care Inpatient Diagnoses 2002

ICD-9 Code	Diagnosis
*****	Deliveries
V30.**	Single Liveborn
493.**	Asthma
486.**	Pneumonia, Organism Unspecified
682.**	Other Cellulitis and Abscess
466.**	Acute Bronchitis and Bronchiolitis
780.**	General Symptoms
644.**	Early or Threatened Labor
786.**	Symptoms Involving Respiratory System and Other Chest Symptoms
276.**	Disorders of Fluid, Electrolyte, and Acid-Base Balance

## Top Ten Medicaid Managed Care Inpatient Behavioral Health Diagnoses 2002

ICD-9 Code	Diagnosis
296.**	Affective Psychoses
295.**	Schizophrenic Disorders
292.**	Drug Psychoses
309.**	Adjustment Reaction
291.**	Alcoholic Psychoses
298.**	Other Non-organic Psychoses
300.**	Neurotic Disorders
312.**	Disturbance of Conduct-Not Elsewhere Classified
311.**	Depressive Disorder-Not Elsewhere Classified
314.**	Hyperkinetic Syndrome of Childhood

## Top Ten Medicaid Managed Care Outpatient Behavioral Health Diagnoses 2002

ICD-9 Code	Diagnosis
309.**	Adjustment Reaction
296.**	Affective Psychoses
300.**	Neurotic Disorders
304.**	Drug Dependence
311.**	Depressive Disorder- Not Elsewhere Classified
295.**	Schizophrenic Disorders
314.**	Hyperkinetic Syndrome of Childhood
313.**	Disturbance of Emotions Specific to Childhood
312.**	Disturbance of Conduct- Not Elsewhere Classified
298.**	Other Non-Organic Psychoses

## IV. GOALS AND STRATEGIES

Specific goals and tactics to achieve the goals and objectives for 2003-2004 include the following:

**A. Support and maintain an information system that collects, analyzes, integrates, and reports data.**

The CMS tools and protocols will be used to the extent applicable to evaluate the MCO and State interface, codes, and translations. Med-QUEST will establish a monitoring process that is consistent with CMS guidelines to examine the information systems of the MCO and Med-QUEST. The EQRO will do a partial review of the information system through HEDIS<sup>®</sup> validation. This will be conducted in March or April of each year. A more complete review of the information systems will be performed as part of the Encounter Data Validation Study. This activity will be performed by the EQRO in three annual stages with a report due at the end of each fiscal year. Each MCO must collect data on recipients and providers and on services furnished to recipients through an encounter data system. The review will validate the accuracy and completeness of MCO data received from providers; the completeness, logic, and consistency of the data; and the use of standardized formats. The MCO's information systems is essential to effectively and efficiently validate encounter data, calculate or validate performance measures and manage the health care of its enrollees. The purpose of this assessment is to identify areas that require improvement with respect to those capabilities.

- a. Information systems used to collect and identify race, ethnicity, and primary language spoken for each QUEST recipient will be examined in the 2003-2004 Strategy. A thorough review of the current policies and procedures for collecting data will be compiled and assessed. The State methodology of enrollment and enrollee rights will be reviewed to assure that disclosure of these facts by enrollees is not used in any potentially adverse way.

Once the current situation is reviewed, assessed and strengths and weaknesses are identified, Med-QUEST can develop action steps to implement, and assure that race, ethnicity, and primary languages spoken are collected in an improved process. Improvements will lead to delivery of services in a culturally competent manner.

- b. Information systems used to identify access to care delivery networks, utilization services, number and types of providers, and geographic locations of providers will be assessed in the 2003-2004 strategy as part of the EQRO annual plan review.

**B. Monitor and support preventive care and EPSDT services activities and develop action plans for deficiencies when indicated.**

- C. Use standardized national HEDIS methodology to measure some compliance rates of Preventive Health Care Services provided to its recipients annually. At least three measures a year will be audited by the EQRO and certified. These measures will be rotated. The certified audits are followed by corrective action plans when appropriate. The CMS 416 report will also be used to measure EPSDT participation. Other measurements may be necessary for data compilation and measurement in specific areas. The measurable objective for the CMS 416 participation rate is 85%. The measurable objectives are set at the national Medicaid HEDIS 90 percentile for each topic.

**PERFORMANCE MEASURES CONDUCTED BY MCO/VA LIDATING CONDUCTED BY EQRO**

**EXAMPLES**

Topic	Rational e	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
Comprehensive Diabetes Care (Hemoglobin A1c Tested and Eye Exam)	↑ Risk	P	C	HEDIS®	HEIDIS Compliant	7/2003	MCO/EQRO							X	X	X	X	X	R
Prenatal and Postpartum Care	↑ Vol. DX	P	C	HEDIS®	HEIDIS Compliant	7/2003	MCO/EQRO							X	X	X	X	X	R
Chemical Dependency Utilization	↑ Vol.	P	C	HEDIS®	HEIDIS Compliant	7/2003	MCO/EQRO							X	X	X	X	X	R

2003-2004 goals will be to measure performance against previous years' performance and set performance goals. Selected measures that have been validated will be published in the annual open-enrollment packets mailed to members.

R =Report  
P =Population Measurement Monitor  
FS =Focus Study on Select Members  
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### EPSDT REPORTING/PERFORMANCE MONITORING

The Managed Care Plan must assure that individuals are informed within sixty (60) days of their MCO enrollment that EPSDT is a benefit. Families that have not utilized EPSDT services of the EPSDT benefit are to be reminded annually.

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
Percent of Eligibles Receiving One (1) Initial Visit or Periodic Screen	CMS ↑ Risk	P	C	CMS 416	85% ↑Rate 10% Gap	7/2003	MCO/MQD						X	X	X	R			
Percent of Eligibles Receiving Vision Screen	CMS ↑ Risk	P	C	CMS 416	85% ↑Rate 10% Gap	7/2003	MCO/MQD						X	X	X	R			
Percent of Eligibles Receiving Hearing Screen	CMS ↑ Risk	P	C	CMS 416	85% ↑Rate 10% Gap	7/2003	MCO/MQD						X	X	X	R			

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**D. Monitor women’s and child health care services and develop action plans for Strategy when indicated.**

Hawaii Medicaid Managed Care will use HEDIS and other methodologies to monitor the compliance rates of women and children’s care that its recipients receive annually. The measures are trended against previous years’ data and may lead to further improvement projects with corrective action as appropriate.

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
Prenatal Care 1st Trimester	↑ Vol. DX	P	C	HEDIS®	↑10% of Gap 94.69	7/2003	MCO/MQD			X	X	X	R						
Postpartum Care	↑Vol. DX	P	C	HEDIS®	↑10% of Gap 86.62	7/2003	MCO/MQD			X	X	X	R						
Breast Cancer Screening	↑ Vol. Risk	P	C	HEDIS®	↑10% of Gap 83.15	7/2003	MCO/MQD			X	X	X	R						
Cervical Cancer Screening	↑ Vol. Risk	P	C	HEDIS®	↑10% of Gap 86.86	7/2003	MCO/MQD			X	X	X	R						
Childhood Immunization (Combo #2)	↑ Vol. Risk	P	C	HEDIS®	↑10% of Gap 71.50	7/2003	MCO/EQRO			X	X	X	R						
Well Child Visits in the 1 <sup>st</sup> 15 Months of Life (6 visits)	↑ Vol. Risk	P	C/S	HEDIS®	↑10% of Gap 81.01	7/2003	MCO/MQD			X	X	X	R						

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**E. Monitor case management/care coordination for Individuals with Special Health Care Needs and develop action plans for Strategy when indicated.**

Med-QUEST and the MCOs will establish criteria for defining the population and methodology to identify, access the needs of those individuals with special health care needs, and provide case management or care coordination. The EQRO will evaluate MCO performance. The population will include both adults and children.

- a. Adults with special health care needs are those individuals 21 years of age and older who have chronic physical or behavioral conditions that require health related services of a type or amount beyond that required by adults generally.
- b. Children with special health care needs are those individuals under 21 years of age who have a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

SHCN Case Management	↑ Vol. Risk	P	C	SHCN Assessment Form/ ICP	TBD	7/2003	MCO/MQD										X			R
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**F. Monitor chronic illness or other services and develop action plans for Strategy when indicated. These conditions have been selected as Performance Improvement Projects.**

Med-QUEST and the MCOs will use HEDIS Hybrid and other methodology to measure the levels of care provided to members of asthma, which is a chronic illness. This study has been selected as a Performance Improvement Project because it ranges across wide groups, which are representative of the Hawaii Medicaid Managed Care population demographics and epidemiology. The asthma study may be a continuation of studies, which were underway. It will particularly impact the special needs population of all ages with this chronic disease. Each plan must pick at a minimum one additional study of their own choosing. The EQRO will examine whichever study is chosen by the plan.

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004	
Asthma	↑ Vole DX Child and Adult	PS	C	Encounter/ HEDIS®	Performance Improvement Project	7/2003	MCO/MQD or EQRO													X
Plan Selected	As Defined by Plan	PS	C	As Selected by Plan	Performance Improvement Project	7/2003	MCO/MQD or EQRO									X				R

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**G. Monitor behavioral health services for quality of care related to major affective disorders.**

Hawaii Medicaid Managed Care will apply the measures and trend against the available previous years' data and if a new measure will establish a baseline. This may lead to further performance improvement studies with resulting corrective action plans when appropriate.

**BEHAVIORAL HEALTH**

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
FU After Hospitalization For Mental Illness - 7 days	↑ DX Specialty	P	C	HEDIS®	↑10% of Gap 51.21	7/2003	MCO/MQD			X	X	X	R						
FU After Hospitalization For Mental Illness - 30 days	↑DX Specialty	P	C	HEDIS®	↑10% of Gap 73.18	7/2003	MCO/MQD			X	X	X	R						

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**H. Monitor health services for access to care.**

Continuous monitoring of key indicators will be essential to ensure compliance with the standards.

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004	
Telephone Access Abandonment Rate	Access to Care	P	S	Key Indicator Report Phone System Reports	5%	7/2003	MCO/EQRO	X	X	X	X	X	X	X	X	X	X	X	X	R
Telephone Access Average Wait Times	Access to Care	P	S	Key Indicator Report Phone System Reports	30 seconds	7/2003	MCO/EQRO	X	X	X	X	X	X	X	X	X	X	X	X	R
Appointment Office Wait Times	Access to Care	P	S	CAHPS® Survey	↑10% of gap	7/2003	MCO/EQRO							X	X	X	X			R

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**I. Conduct recipient and provider satisfaction surveys and analysis of grievances.**

Monitor recipient grievances to assure enrollees are receiving benefits based upon the Medicaid Managed Care offering and rendered within quality parameters.

**GRIEVANCES AND APPEALS**

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
Grievances /1000	Service Dissatisfaction	P	S	Reporting Guide Trend	<10/1000	7/2003	MCO/MQD	X	R	X	X	R	X	X	R	X	X	R	R
Grievance Turnaround Time	Member perception Service Dissatisfaction	P	S	Grievance Forms Trend	Contract Standards	7/2003	MCO/EQRO	X	R	X	X	R	X	X	R	X	X	R	R
Access to Care	Member perception Service	P	S/C	Grievances Forms CAHPS®	Contract standards	7/2003	MCOEQRO	X	R	X	X	R	X	X	R	X	X	R	R
Quality of Care	Service Dissatisfaction Quality Monitoring/	P	S/C	Grievances Forms CAHPS® Plan Documents	<5/1000	7/2003	MCO/MQD/EQRO	X	R	X	X	R	X	X	R	X	X	R	R

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### RECIPIENT SATISFACTION SURVEY

Recipient satisfaction surveys will be conducted by the EQRO using CAHPS methodology as scheduled to assess satisfaction with the access, quality of care and quality of service provided to the recipients.

Topic	Rationale	Study Population	Type	Methodology	Measurable Objective	Contract Years	Accountability	Jul 2003	Aug 2003	Sept 2003	Oct 2003	Nov 2003	Dec 2003	Jan 2004	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
General Satisfaction With Health Plan	Member perception	P	S	CAHPS® Survey	↑10% of Gap	7/2003	MCO/EQRO							X	X	X	R		R
General Satisfaction with Personal Doctor	Member perception	P	S	CAHPS® Survey	↑10% of Gap	7/2003	MCO/EQRO							X	X	X	R		R
Getting Needed Care	Member perception Compliance by providers and plan	P	S	CAHPS® Survey Grievance Forms Utilization Review	↑10% of Gap Meet Contract Standards	7/2003	MCO/EQRO							X	X	X	R		R
Getting Care Quickly	Member perception Compliance by Providers	P/FS	S	CAHPS® Survey MCO Phone or/and mail survey	↑10% of Gap Meet Contract Standards	7/2003	MCO/EQRO							X	X	X	R		R
Plan Customer Service	Member perception	P	S	CAHPS® Survey	↑10% of Gap	7/2003	MCO/EQRO							X	X	X	R		R

### PROVIDER SATISFACTION SURVEY

Provider satisfaction surveys of both primary care providers and specialists will be scheduled every other year to assess satisfaction with managed care, the MCOs, the Med-QUEST program, reimbursement, MCO formularies, MCO utilization management and quality of care. The next survey will be conducted in 2004-2005.

**J. Conduct annual contract structure and operations compliance audits to determine the MCO's compliance with the standard set forth in the agreement between the State and the contractors. These audits will be conducted by the EQRO. The audits will be followed by corrective action as an improvement plan and/or sanctions. The improvement plan will be monitored by the EQRO or Med-QUEST Division.**

**STANDARD I: WRITTEN QAP DESCRIPTION** – The Contractor has a written description of its QAP. This written description meets the following criteria:

**STANDARD II: SYSTEMATIC PROCESS OF QUALITY ASSESSMENT AND IMPROVEMENT** – The QAP objectively and systematically monitors and evaluates the quality and appropriateness of care and service to participants, through quality-of-care studies and related activities, and pursues opportunities for improvement on an ongoing basis.

**STANDARD III: ACCOUNTABILITY TO THE GOVERNING BODY** – The Governing Body of the Contractor is the Board of Directors or, where the Board's participation with quality improvement issues is not direct, a designated committee of the senior management of the Contractor is responsible for the Contractor QAP review. Responsibilities of the Governing Body for monitoring, evaluating and making improvements to care include:

**STANDARD IV: ACTIVE QA COMMITTEE** - The QAP delineates an identifiable structure responsible for performing QA functions within the contract. This committee or other structure has:

**STANDARD V: QAP SUPERVISION** – There is a designated senior executive who is responsible for program implementation. The Contractor's Medical Director has substantial involvement in QA activities.

**STANDARD VI: ADEQUATE RESOURCES** – The QAP has sufficient material resources and staff with the necessary education, experience, or training to effectively carry out its specified activities.

**STANDARD VII: PROVIDER PARTICIPATION IN QAP**

**STANDARD VIII: DELEGATION OF QAP ACTIVITIES** – The Contractor remains accountable for all QAP functions, even if certain functions are delegated to other entities. If the Contractor delegates any QA activities to contractors:

**STANDARD IX: CREDENTIALING AND RE-CREDENTIALING** – The QAP contains the following provisions to determine whether physicians and other health care professionals, who are licensed by the State and who are under contract to the Contractor, are qualified to perform their services.

**STANDARD X: PARTICIPANT RIGHTS AND RESPONSIBILITIES** – The Contractor demonstrates a commitment to treating participants in a manner that acknowledges their rights and responsibilities.

**STANDARD XI: STANDARDS FOR AVAILABILITY AND ACCESSIBILITY** – The Contractor has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and recipient service lines). Performance on these dimensions of access is assessed against the standards.

**STANDARD XII: MEDICAL RECORD STANDARDS**

- i. Accessibility and Availability of Medical Records
- ii. Record Keeping Record Review Process

**STANDARD XII: UTILIZATION REVIEW**

- A. Written Program Description
- B. Scope
- C. Pre-Authorization and Concurrent Review Requirements

**STANDARD XIV: CONTINUITY OF CARE SYSTEM** – The Contractor has put a basic system in place, which promotes continuity of care and case management.

**STANDARD XV: QAP DOCUMENTATION**

- A. Scope
- B. Maintenance and Availability of Documentation

**STANDARD XVI: COORDINATION OF QUALITY ASSURANCE ACTIVITY WITH OTHER MANAGEMENT ACTIVITY** – The findings, conclusions, recommendations, actions taken and results of the actions taken as a result of QA activity, are documented and reported within the Contractor’s organization and through the established QA channels.

**STANDARD XVII: DATA COLLECTION** – The Contractor must provide Med-QUEST with uniform utilization, cost, quality assurance, and recipient satisfaction/complaint data on a regular basis, in accordance with RFP Sections 57.000, 57.100, and 57.200.

**STANDARD XVIII: DISPUTE RESOLUTION** – The Contractor must staff a provider services unit to handle provider questions and disputes.

**K. Conduct periodic surveys of recipient access to health care services.**

The annual member satisfaction survey listed above addresses member satisfaction with access to health care. Also, MCOs conduct audits of physical offices to determine handicap accessibility, and the availability of appointments for emergent, urgent, routine, and periodic health exam services. The MCO’s facility site audit will be reviewed by the EQRO at the time of the annual plan audit to determine the validity of the methodology.

**L. Monitor Over-and Under-Utilization of health care services.**

The MCOs will monitor both the over-utilization and under-utilization of health care services. They will develop a system that will identify practice patterns by diagnosis and treatment. Action plans will be developed for improvement and will assure appropriate access to services.

**M. MCO Profiling will be conducted based upon a combination of all measures, audits and studies. At a minimum this will include the results of the annual EQRO audit, HEIDIS compliance audit, and CAHPS Consumer Satisfaction Survey**

**N. An intermediate sanction system will be further developed based upon the 2003 contract with the MCOs and results of profiling.**

**O. The Annual Quality Assessment and Improvement Evaluation will be conducted for the previous calendar year following receipt of the HEDIS information and EQRO reports. The annual Work Plan will be built from the Evaluation.**

## **V. CONFIDENTIALITY**

Patient information documents created because of this Quality Assessment and Performance or Work Plan will be maintained as confidential.

## VI. OVERSIGHT AND DIRECTION

- A. The Med-QUEST Division meets regularly and is the body in which responsibility for the overall Strategy resides.
- B. The MCO/Med-QUEST quarterly Medical Directors/Administrators meeting is held and exercises oversight through a standing agenda item of the overall Strategy and Work Plan.
- C. The MCO maintains internal control of the processes and will be responsible to resolve issues identified through the survey, service complaints, PCP changes, and activities related to operations, claims, information system, customer service, marketing, and contracting and medical departments. Activities conducted by Med-QUEST will be coordinated with all MCOs and input will be received to assure that all systems affected are involved in the improvement process.
- E. Other committees and multi-disciplinary bodies are formed to meet on a temporary or permanent basis to fulfill the quality improvement needs of the State.

## VII. REVIEW AND APPROVAL

The stakeholders, recipients and public exercise oversight by reviewing and providing feedback to the State on the Strategy and Work Plan.

Dates of Stakeholder meetings	April 15, 2003--April 22, 2003--May 16, 2003—May 9, 2003	Approval
Dates of Recipient Input	Above Dates	_____
Date of Public Information Disclosure	Expected Date June 17, 2003	_____
Date of Approval by Med-QUEST Division	_____	_____