

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

***QUALITY ASSESSMENT AND  
PERFORMANCE IMPROVEMENT  
STRATEGY***

# Table of Contents

- I. QUALITY STRATEGY..... 1**
- II. SCOPE ..... 3**
- III. HAWAII MANAGED CARE MEDICAID QUALITY MISSION ..... 4**
- IV. PURPOSES OF THE STRATEGY..... 5**
- V. FUNCTIONS AND ACTIVITIES..... 6**
- STRATEGY ADMINISTRATION AND OVERSIGHT ..... 8**
  - A. Authority and Responsibility..... 8*
  - B. Program Organizational Structure..... 8*
  - C. Annual Strategy Evaluation ..... 8*
  - D. Work Plan ..... 9*
- VI. STATE QUALITY DEPARTMENT ..... 10**
  - A. Purpose ..... 10*
  - B. Quality Improvement Activities..... 10*
    - 1. Performance Measurement Validation ..... 10
    - 2. Annual Consumer Satisfaction Survey ..... 10
    - 3. PIHP Contract Compliance Performance ..... 10
    - 4. Performance Improvement Projects..... 10
    - 5. Process/Quality Improvement Plan..... 11
    - 6. Continuous Monitoring and Reassessment..... 11
  - C. Conflict of Interest ..... 11*
- VII. APPROVAL ..... 13**

## *I. QUALITY STRATEGY*

The State of Hawaii Department of Human Services is required to develop a Hawaii Medicaid Managed Care Quality Assessment and Improvement Strategy (Strategy), pursuant to 42 CFR 438.200. A separate strategy has been developed for the Managed Care Organizations (MCOs). The Child and Adolescent Mental Health Division (CAMHD) has been identified as a Prepaid Inpatient Health Plan (PIHP) and is required to have a Quality Strategy. This Strategy has two parts, a comprehensive program and an annual Work Plan.

The Hawaii Medicaid Managed Care Quality Assessment and Improvement Strategy incorporates policies; procedures; contract compliance; and input from the public, stakeholder providers, recipient advocates and multiple State of Hawaii departments that hold an interest in the improvement of access and of clinical and service quality received by the Medicaid recipients.

All quality activities for Medicaid/CAMHD population are integrated into a single Strategy, which applies throughout the Hawaii Medicaid Managed Care service area. The Med-QUEST Division oversees the Strategy to verify that the performance of quality improvement functions is timely, consistent, and effective.

The Strategy is designed with the intent that services provided to recipients meet established standards for access to care, clinical quality of care and quality of service, and that opportunities to improve these areas are identified and acted upon. The Strategy is designed to identify, document, and review access, quality of care, and service issues, and to verify that appropriate corrective actions are taken to address these issues.

The Strategy features:

- Assessment and improvement of quality of care and services through use of monitoring and national benchmarks for the Medicaid CAMHD population.
- Focused audits.
- Studies.
- Assessment of recipient and provider satisfaction.
- Review of potential quality issues, recipient appeals and grievances,
- Review of access to care through analysis of provider networks using contract and credentialing criteria by CAMHD.
- Compliance with contractual operations and organizational structure.

The Strategy is multi-disciplinary with the collaboration of identified stakeholders, recipients and the public.

The Child and Adolescent Mental Health Division (CAMHD) has been identified as the major stakeholder in the development of this Quality Strategy. AlohaCare, Hawaii Medical Services Association, and Kaiser Permanente have been identified as stakeholders since the majority of the Medicaid/CAMHD population are enrolled in their QUEST Managed Care Organizations and have been invited to a stakeholder meeting. Public agencies identified as stakeholders

include Child Protective Services (CPS), Children with Special Health Care Needs Branch, and the Department of Education (DOE). A minimum of six parents/guardians of Medicaid/CAMHD enrolled recipients from CAMHD will be identified and invited to participate in the recipient stakeholders' meeting. In addition, at least six of CAMHD's network providers will be invited to participate in a provider stakeholders' meeting. These providers must be clinicians rather than administrators and may be licensed behavioral health providers or other agencies from the following fields of practice: mental health, residential facilities, and/or specialty providers. CAMHD is invited to send representatives to the stakeholders' meetings.

Following the stakeholders' meetings, the State will provide public notice in order to afford the opportunity for the public to be aware of the Quality Strategy and to offer comments for future consideration.

Following the public notice, the proposed Quality Strategy will be provided to Centers for Medicare & Medicaid Services (CMS) for approval no later than July 15, 2003. The finalized Quality Strategy will become effective on August 13, 2003 with the execution of the new Memorandum of Agreement and will be reviewed by the state quarterly, as a standing agenda item, during regularly scheduled CAMHD/MQD Administrators meetings and teleconferences. The State, in turn, will provide quarterly updates to CMS with regard to the status of the State's Quality Strategy for CAMHD and will provide CMS with written revisions to the Quality Strategy whenever significant revisions are made to the Strategy. A copy of the annual Work Plan will be submitted to CMS each year.

The program is reviewed, evaluated and updated annually or more often as additional information becomes available.

## *II. SCOPE*

The Strategy is comprehensive, systematic, and continuous. The scope of the Strategy may be amended as necessary to support the continuous quality improvement process. The Strategy will be amended to reflect changes in scope and identified needs. Significant changes to the Strategy that will require input from recipients and stakeholders are defined as:

- Any change to the Strategy resulting from legislated, state, federal or other regulatory authority.
- Any change in membership demographics of 50 percent or greater within one (1) year.
- Any change in the provider network of 50 percent or greater within one (1) year.
- Any change in the scope of services of 50 percent or greater within one (1) year.

The following are included in the scope of the Strategy:

1. All Medicaid recipients included in all demographic groups and in all service areas for which the CAMHD are approved to provide Medicaid Managed Care services.
2. All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by CAMHD for Medicaid.
3. All aspects of PIHP performance relating to access to care, quality of care and service—including networking contracting and credentialing, medical record-keeping, health management, and health promotion.
4. All services covered—including crisis management, outpatient behavioral health services, intensive family intervention services, crisis residential services, intensive outpatient hospital services, therapeutic living supports and therapeutic foster care supports, and residential treatment in a hospital setting.
5. All professional and institutional care in all settings, including residential, outpatient, and home settings.
6. All providers and any other delegated or subcontracted provider type.
7. All aspects of CAMHD internal administrative processes which are related to service and quality of care—including customer services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, behavioral health services, information services, and quality improvement.

### *III. HAWAII MANAGED CARE MEDICAID QUALITY MISSION*

The program seeks to demonstrate that managed care using a significant purchasing pool, utilizing a standard benefit package and focusing on preventive care can deliver quality medical services at an affordable price.

The QUEST program acronym stands for the following:

- **Quality of Care**
- **Universal Access**
- **Efficient Utilization**
- **Stable Cost**
- **Transformation**

#### *IV. PURPOSES OF THE STRATEGY*

1. Monitor and verify that services provided to the recipients conform to professionally recognized standards of practice and code of ethics.
2. Identify through monitoring activities and pursue opportunities for improvements in the health status of the enrolled population through case management services, disease and special needs management.
3. Identify through monitoring activities and pursue opportunities for improvements in quality of care and quality of service.
4. Monitor, access and pursue opportunities for improvements in accessibility of care and consumer satisfaction with care and service.
5. Foster a multi-disciplinary approach to quality improvement by the identification and pursuit of opportunities to partner with other State agencies and stakeholders and integrate common goals into the Strategy.
6. Provide direction and guidance for all staff in the pursuit of the Strategy goals.
7. Monitor processes to identify race/ethnicity and primary languages spoken and increase cultural sensitivity and access to culturally appropriate services.
8. Assure an information system is in place that will support the efforts of the Strategy.
9. Pursue improvement in provider satisfaction and provider participation.

## V. *FUNCTIONS AND ACTIVITIES*

The following table demonstrates responsibility for the described functions and activities:

<b>Functions and Activities</b>		<b>Responsibilities</b>	
		<b>PIHP</b>	<b>Med-QUEST</b>
1.	Establish and maintain standards for quality of care, accessibility of care, and services.	√	
2.	Perform performance improvement and related activities, with emphasis on high volume /high-risk services. On-going activities are preventive services, over- and under-utilization, and continuity of care.	√	
3.	Perform and/or monitor consumer satisfaction surveys and take action, where appropriate, to improve satisfaction.	√	√
4.	Receive, investigate, and resolve recipient appeals and grievances as related to access to care, quality of care, and service issues.	√	√
5.	Monitor and evaluate covered health care services rendered to recipients through the use of audits, data collection, performance improvement activities, and outcome assessments.		√
6.	Conduct contract compliance reviews of PIHP for structure and operational compliance with the standards as well as compliance with appropriate state and federal regulatory requirements.		√
7.	Conduct a review of a sample of network providers' recipient medical records to achieve compliance with standards for medical record-keeping practices, continuity of care, clinical services, and other aspects of care.	√	√
8.	Conduct a proactive review of potential quality issues. Identify and resolve potential quality issues as appropriate.	√	√
9.	Conduct review of utilization review activities to ensure that these activities do not have a negative impact on quality of care. Activities that will be monitored are denials of authorizations and grievances.		√
10.	Review the credentialing activities of the PIHP and its subcontractors and providers.		√

<b>Functions and Activities</b>		<b>Responsibilities</b>	
		<b>PIHP</b>	<b>Med-QUEST</b>
11.	Ensure that an accurate provider network is presented by the PIHP to the public.		√
12.	Monitor to assure contracts between the PIHP and its delivery network meet the minimum qualifications to assure compliance with benefits delivery and operations.		√
13.	Review PIHPs' internal practices regarding the handling of medical record information to achieve compliance with confidentiality policies and enrollee rights.		√
14.	Review PIHPs' quality improvement activities to achieve compliance with the requirements of the MOA.		√
15.	Establish, maintain and enforce a public review, input and feedback policy regarding strategy activities.		√
16.	Conduct an annual evaluation of the Strategy activities and effectiveness and report this evaluation to CMS. Stakeholders and others will be supplied a copy upon request.		√
17.	Prepare an annual Quality Strategy Work Plan describing the activities to be undertaken in the upcoming year.		√
18. 4	Make modifications to the overall Strategy as needed.		√

# *STRATEGY ADMINISTRATION AND OVERSIGHT*

## **A. Authority and Responsibility**

1. The Med-QUEST Division has the authority and responsibility to establish, maintain, and support a multidisciplinary approach to quality that engages stakeholders, recipients, the public and other agencies.
2. The Med-QUEST Division has the authority and responsibility to establish, maintain, and support an effective Strategy on a continuous basis.

## **B. Program Organizational Structure**

1. The Med-QUEST Division approves the Strategy and maintains ultimate authority for overseeing its management and direction. The Strategy delegates the authority and responsibility for the development and implementation of effective management of the Strategy to the Health Coverage Management Branch and Medical Standards Branch of the Med-QUEST Division. The Health Coverage Management Branch is responsible for reporting quality Strategy activities, findings, and actions to the stakeholders, public, legislators, governor, and CMS.
2. The Med-QUEST Division oversees the Strategy's overall effectiveness and performance of staff in carrying out the requirements, and reviews and approves the Strategy itself.
3. The public, recipients and stakeholders provide input and recommendations regarding the content and direction of the Strategy. They will make recommendations regarding the delivery of quality care and service according to recognized standards of practice.
4. The Health Coverage Management Branch of the Med-QUEST Division has management responsibilities for the Strategy. The Medical Standards Branch has clinical responsibility for the Strategy. The Medical Standards Branch reviews and reports clinical issues, formulates policies and procedures, and makes recommendations to the Med-QUEST Division.

Multi-disciplinary committees may be formed to address specific quality initiatives and/or issues.

## **C. Annual Strategy Evaluation**

1. At least annually, the Med-QUEST Division reviews data and reports of the Strategy activities and findings to assess the effectiveness of the Strategy. This evaluation includes a review of completed Strategy activities, trending of clinical and service monitors, effectiveness of the Strategy monitoring and review activities, effectiveness of the Strategy in identifying quality of care performance issues, and the success of the Strategy in improving recipient care and provider performance.

In addition, the Med-QUEST Division finalizes the Strategy Evaluation by completing the assessment of areas not reviewed by the External Quality Review Organization (EQRO).

2. The evaluation is completed following the collection of the State fiscal year performance data and consumer satisfaction survey results.
3. The evaluation is available to the Stakeholders, recipients, and the public. The evaluation is the basis for establishing the next year's Strategy and Work Plan.

## **D. Work Plan**

Each year a Quality Strategy Work Plan (Work Plan) is prepared based on the results of the Annual Evaluation. The Work Plan is approved by the Med-QUEST Division. The Work Plan is not a static document. It will be updated as processes change and activities are completed. The Work Plan will reflect progress throughout the year. The Work Plan includes a description of:

1. The objectives, scope, methodology, and planned activities to be undertaken in the coming year.
2. Monitoring of previously identified issues, including tracking of issues over time.
3. The time frames for activities, reports and results.
4. The responsible entity or individual for each activity.
5. Planned evaluation of the Strategy.

## ***VI. STATE QUALITY DEPARTMENT***

### **A. Purpose**

The Medical Standards Branch of the Med-QUEST Division is responsible to develop processes that track and measure the efficiency and effectiveness of care and service. This is partially accomplished by the implementation of an External Quality Review (EQR) by a qualified vendor. The Medical Standards Branch is responsible to oversee the work of the EQR vendor. The Medical Standards Branch is also responsible to review and approve the EQR contract deliverables.

### **B. Quality Improvement Activities**

#### **1. Annual Performance Measurement Validation**

Validation of the performance measures are developed and performed by the EQRO in coordination with the State Quality Department and CAMHD. The performance measures that are selected for monitoring are listed in the Work Plan. They may vary from year to year.

#### **2. Annual Consumer Satisfaction Survey**

A consumer satisfaction survey is conducted annually. The most suitable validated survey tool will be utilized.

#### **3. PIHP Contract Compliance Performance**

The EQRO conducts annual Medicaid PIHP Operations related oversight of the Quality of PIHP services. The specific areas of oversight are contained in the Work Plan. The EQRO is also responsible to conduct follow-up in those areas requiring a Process/Quality Improvement Plan. Intermediate sanctions may be necessary and are defined in the contractual relationship between the PIHP and the Med-QUEST Division.

#### **4. Performance Improvement Projects**

Performance Improvement Projects have been identified and will be managed through phases of activities over time. The projects will follow current CMS guidelines.

Focused studies will be evaluated to determine whether a performance improvement project should be conducted. If the activity criteria element does not apply, the study will be scored N/A for that element. Elements scored N/A will not be included in the total score. The Work Plan describes the identification and rationale of projects.

## **5. Process/Quality Improvement Plan**

A process or quality improvement plan will be requested from the PIHP in cases for which the process or monitor reviewed does not reach performance standards. The improvement plan should include clearly stated objectives and time frames for completion. The corrective action plans may include but are not limited to:

- Education, by oral or written contact, or through required further training.
- Re-certification for procedures or services that require certification.
- Required submission of a corrective action plan, with subsequent monitoring or re-auditing to confirm compliance with said action plan.
- Prospective or retrospective trend analysis of the patterns or trends.
- In-service training.
- Provider education.
- Modification, suspension, restriction, or termination.
- Intensified review.
- Changes to administrative policies and procedures, as appropriate.

## **6. Continuous Monitoring and Reassessment**

To prevent recurrence of corrected quality issues; the PIHP is monitored and/or reassessed to confirm that the corrective action has resolved the issues. Quality issues remain an open item until resolved. Improvements in patient care and service resulting from corrective action are documented appropriately.

## **C. Conflict of Interest**

No member of a Strategy development team or the review entity will have a conflict of interest. Members will not review or participate in the review of their own services, MCO/PIHP, or direct competitors or be associated through financial arrangements. Any unresolved concerns for State employees will be directed to the State Ethics Commission for review and for others, to the State Attorney General's Office.

Upon request, the Med-QUEST Division will provide the recipients, providers, stakeholders and the public with written information.

***VII. APPROVAL***

The Strategy was reviewed and approved by the following Med-QUEST Division and Department of Human Services personnel:

Date: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_