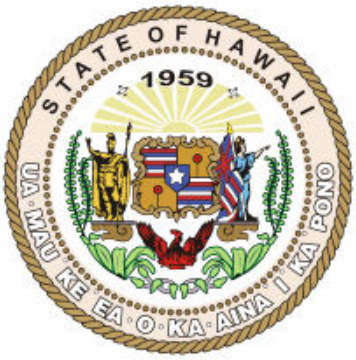
State of Hawaii

Department of Human Services
Med-QUEST Division



2014 External Quality Review Report of Results *for the* QUEST and QUEST Expanded Access Health Plans and the Community Care Services Program

November 2014

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Overview

The 2014 Hawaii External Quality Review Report of Results for the QUEST and QUEST Expanded Access (QExA) Health Plans and the Community Care Services (CCS) Program is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR 438.364. Health Services Advisory Group, Inc. (HSAG) is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), the single State agency responsible for the overall administration of Hawaii's Medicaid managed care program.

This report describes how data from activities conducted in accordance with 42 CFR 438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid recipients by the five QUEST health plans, two QExA health plans, and the CCS program. The QUEST health plans were AlohaCare QUEST (AlohaCare), Hawaii Medical Service Association QUEST (HMSA), Kaiser Permanente Hawaii QUEST (Kaiser), 'Ohana Health Plan ('Ohana), and UnitedHealthcare Community Plan (UHC CP). The QExA plans were 'Ohana and UHC CP; these two plans served both QUEST and QExA enrollees. 'Ohana also held the contract for the CCS program operational since March 2013. CCS is a carved-out behavioral health specialty services plan for QExA-enrolled individuals determined by the MQD to have a serious mental illness.

According to the managed care regulations (42 CFR 438), the QUEST and QExA health plans qualify as managed care organizations (MCOs) and the CCS program meets the definition as a pre-paid inpatient health plan (PIHP). For discussion purposes throughout this report, the Hawaii MCOs and PIHP will be referred to as "health plans" unless there is a need to distinguish a particular plan type.

HSAG's external quality review (EQR) of the health plans included directly performing the three federally mandated activities as set forth in 42 CFR 438.358—a 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®)[1-1] compliance audits, and validation of performance improvement projects (PIPs). One optional EQR activity was also performed this year: Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] surveys of Medicaid adult members and Children's Health Insurance Program (CHIP) child members using the CAHPS 5.0H Adult Medicaid and Child Medicaid CAHPS survey instruments. While the adult survey was conducted at the plan level and provided results at a plan-specific and statewide aggregate level, the child CHIP survey was conducted at a statewide level due to small enrollment numbers, producing statewide aggregate results.

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

This report includes the following for each EQR activity conducted:

- Objectives
- Technical methods of data collection and analysis
- A description of data obtained
- Conclusions drawn from the data

In addition, an assessment of the strengths and weaknesses of each health plan, as well as plan comparative information, is included. The report also discusses the status of improvement activities initiated by the health plans and offers recommendations for improving the quality and timeliness of, and access to, health care services provided by each health plan.

This is the tenth year HSAG has produced the EQR report of results for the State of Hawaii. Report information does not disclose the identity of any patient, in accordance with 42 CFR 438.364(c).

External Quality Review Activities, Conclusions, and Recommendations

HSAG, as the EQRO for the MQD, conducted EQR activities and analyzed the results as described in the next sections of this report. HSAG also offered conclusions and recommendations for improvement to the QUEST, QExA, and CCS health plans.

Compliance Monitoring Review of Standards

Description

For the 2014 evaluation of health plan compliance, HSAG used standardized monitoring tools to assess and document the health plans' compliance with a select set of standards and requirements. The standards selected for review were related to the health plans' State contract requirements and the federal Medicaid managed care regulations in the Code of Federal Regulations (CFR). Both a pre-on-site desk review and an on-site review with interview sessions were conducted.

Findings, Conclusions, and Recommendations

The following table illustrates each health plan's individual performance in each of the standard areas and a statewide total score for each standard and for the health plans overall.

Table 1-1—Compliance Standards and Scores										
Standard #	Standard Name	AlohaCare QUEST	HMSA QUEST	Kaiser QUEST	'Ohana QUEST	'Ohana QExA	'Ohana CCS	UHC CP QUEST	UHC CP QExA	Statewide All Plans
I	Provider Selection	100%	100%	100%	100%	100%	100%	100%	100%	100%
II	Subcontracts and Delegation	95%	100%	88%	100%	100%	100%	100%	100%	98%
III	Credentialing^	100%*	100%	100%*	100%*	100%*	100%*	100%	100%	100%
IV	Quality Assessment and Performance Improvement	100%	100%	92%	100%	100%	100%	100%	100%	98%
V	Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%
VI	Practice Guidelines^	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Compliance Score:		99%	100%	97%	100%	100%	100%	100%	100%	99%

Scores were calculated by assigning 1 point to *Met* items, 0.5 points to *Partially Met* items, and 0 points to *Not Met* and *NA* items, then dividing the total by the number of applicable items.

^Some Credentialing and Practice Guidelines elements were "deemed" compliant for certain health plans. See Appendix B of this report for details regarding the deemed compliance decisions.

* Although three Credentialing elements (related to provider disclosures) were "Not Scored", they were not fully met by these plans and required corrective actions to address identified deficiencies.

Statewide performance across all standards was quite strong, with an overall statewide score of 99 percent. Three plans (HMSA, UHC CP QUEST, and UHC CP QExA) fully met all standards and required no corrective actions. The remaining five plans had relatively strong performance also, with few findings requiring corrective actions. The Hawaii health plans demonstrated continuing maturation as Medicaid managed care plans through these high levels of performance and compliance.

Each health plan received a detailed written report of findings and, if applicable, recommendations and was required to develop and implement a corrective action plan (CAP) for all items not fully *Met*. The MQD and HSAG reviewed and approved the plans' CAPs and will provide follow-up monitoring within the next several months until the identified deficiencies are resolved.

Validation of Performance Measures—HEDIS Compliance Audits

Description

HSAG performed independent audits of the HEDIS and performance measure data for the QUEST, QExA, and CCS health plans consistent with the *2014 NCQA HEDIS Compliance Audit*[1-3]

[1-3] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Standards, Policies, and Procedures, HEDIS Volume 5, and with the CMS protocol for performance measure validation. Each HEDIS Compliance Audit (for the QUEST and QExA health plans) incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. The performance measure validation for CCS included a review of the 'Ohana CCS program's ability to collect and report on a set of HEDIS and non-HEDIS measures relevant to behavioral health.

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*
- *Breast Cancer Screening*
- *Chlamydia Screening in Women*

The six measures reviewed for the QExA health plans were:

- *Controlling High Blood Pressure*
- *Comprehensive Diabetes Care*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care*
- *Inpatient Utilization—General Hospital/Acute Care*
- *Plan All-Cause Readmissions*

The 10 measures reviewed for the CCS program included seven HEDIS Medicaid measures and three non-HEDIS measures:

- *Follow-Up After Hospitalization for Mental Illness*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- *Mental Health Utilization*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Follow-Up with Assigned PCP After Hospitalization for Mental Illness*
- *Behavioral Health Assessment*
- *Plan All-Cause Readmissions*

The measurement period was calendar year (CY) 2013 (January 1, 2013, through December 31, 2013) and the audit activities were conducted concurrently with HEDIS 2014 reporting. There were five QUEST plans (AlohaCare, HMSA, Kaiser, 'Ohana, and UHC CP) and two QExA plans ('Ohana and UHC CP) subject to HSAG's HEDIS audit activities this year. As 'Ohana's CCS program began operations on March 1, 2013 and did not have a full calendar year of data for the measurement period for some measures, HSAG's performance measure validation included validating those measures not requiring a full data year and conducting a "system readiness" review to assess the plan's readiness in using its various data systems and processes for collection and calculation of CCS-specific measures for the next year. 'Ohana CCS was evaluated to be sufficiently prepared to collect and report measure data for its CCS population.

Findings, Conclusions, and Recommendations

HSAG evaluated each health plan's compliance with the National Committee for Quality Assurance's (NCQA's) IS standards and found that all health plans were fully compliant with all standards and able to report valid performance measure rates.

All plans except Kaiser used software, the source code of which had been certified by NCQA, to generate the HEDIS measures. Kaiser calculated the required measures using internally developed programming code. Most plans used supplemental pharmacy and lab data to augment their internal claims/encounter data, which is allowable for HEDIS reporting.

HSAG analyzed the performance measure results separately for the health plans because of differences in the populations served. For each performance measure indicator, HSAG compared the results to the national Medicaid HEDIS 2013 means and percentiles. In general, the MQD Quality Strategy target is the national HEDIS 2013 Medicaid 75th percentile. However, for the inverse measure indicators (e.g., *HbA1c Poor Control [>9.0%]*, *Well-Child Visits in the First 15 Months of Life--0 Visits*, *Plan All-Cause Readmissions*, and *Ambulatory Care–ED Visits)* where a lower rate indicates better performance, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied.[1-4]

The "n" in the following figures indicates the number of indicators in the QUEST and QExA plans' performance measures that fell within the designated percentile range compared to the HEDIS 2013 national Medicaid percentiles. Rates representing a population too small for reporting purposes were referred to as "*Not Applicable*" or *NA*, and were not included in the performance calculations.

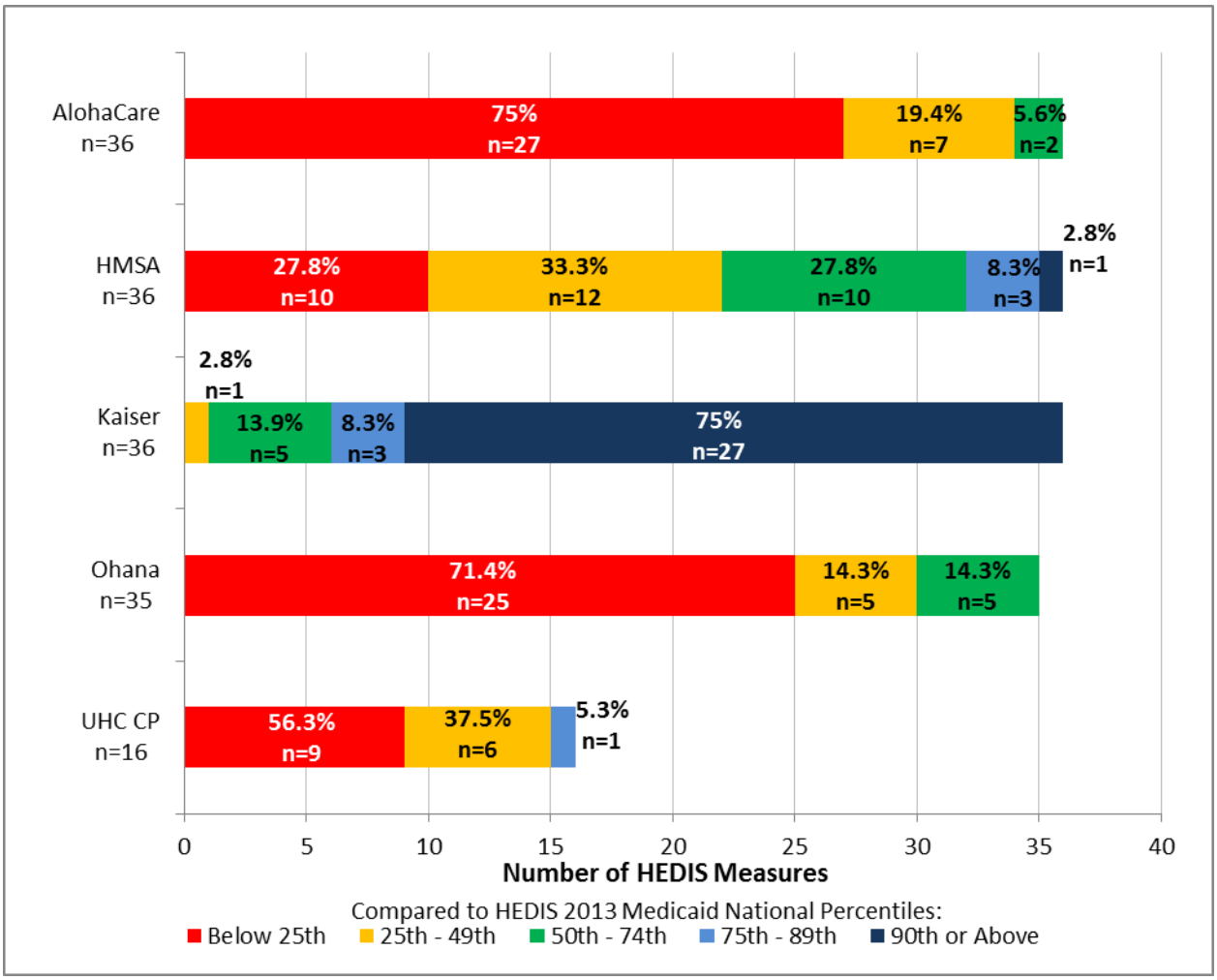
Similarly, for the seven 'Ohana CCS-specific measures that followed HEDIS Medicaid calculation and reporting specifications, HSAG compared the results to the national Medicaid HEDIS 2013 means and percentiles. Figure 1-3 displays the number of CCS indicators that fell within the designated percentile range based on the HEDIS 2013 national Medicaid percentiles.

HSAG validated six performance measures for HEDIS 2014 for the QUEST and QExA health plans, resulting in a total of 36 separate indicator rates reported across all audited measures. Three QUEST plans were able to report all 36 indicators. 'Ohana and UHC CP had one and 20 indicators,

[1-4] For example, because the value associated with the national 10th percentile reflects better performance, HSAG reversed the percentile to the measure's 90th percentile. Similarly, the value associated with the 25th percentile was reversed to the 75th percentile. This value also serves as the MQD Quality Strategy target.

respectively, with denominator(s) less than 30 and therefore could not report a valid rate. For those indicators, these two QUEST plans received an audit result of *NA* (small denominator). Figure 1-1 shows the QUEST plans' performance on the indicators compared to the national percentiles.

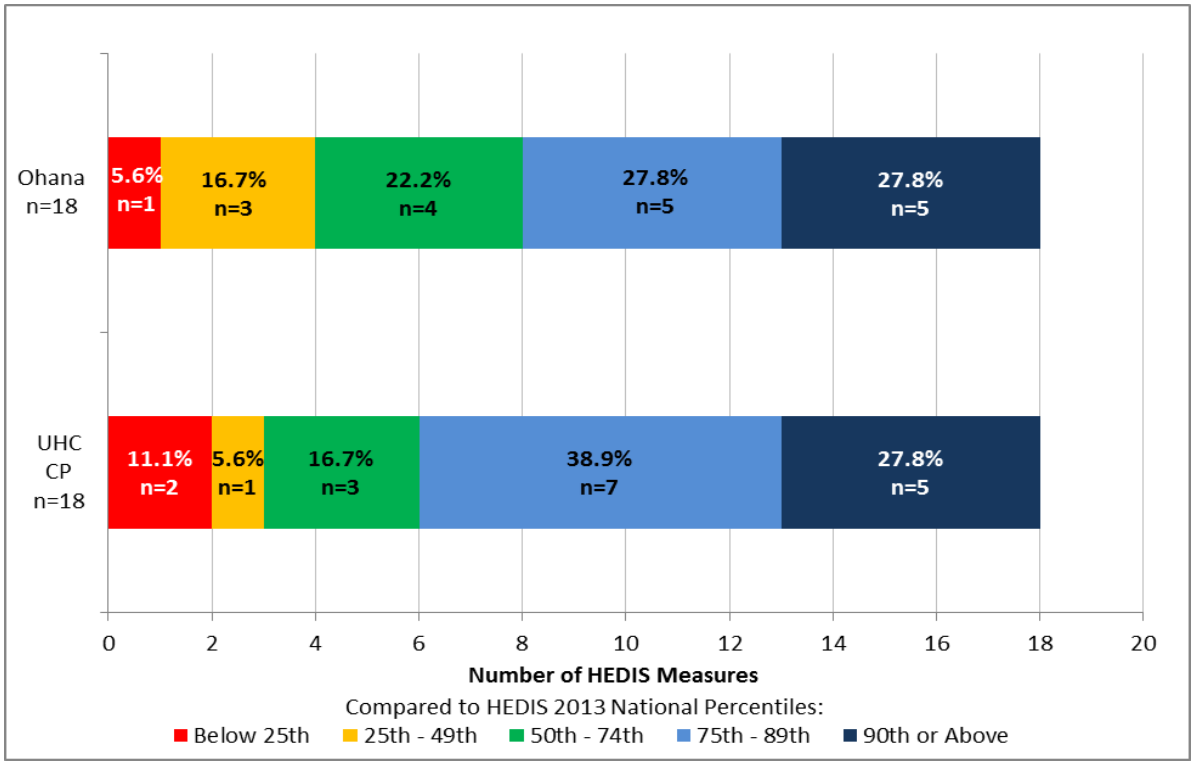
Figure 1-1—Comparison of QUEST Plan Indicators to HEDIS Medicaid National Percentiles



The QUEST plans were diverse in their performance. Kaiser, the best performing plan for HEDIS 2014, reported 75 percent of its indicators (27 of 36) at or above the HEDIS 2013 national Medicaid 90th percentile. Together with three indicators reporting at or above the national 75th percentile, Kaiser had a total of 30 rates meeting the MQD Quality Strategy targets. HMSA reported 14 out of 36 rates above the 50th percentiles, including three rates above the 75th percentiles and one rate above the 90th percentile. AlohaCare, 'Ohana, and UHC CP had below average performance, reporting more than 50 percent of their measures with valid rates below the HEDIS 2013 national 25th percentile. UHC CP had one rate above the national 75th percentile, meeting the MQD Quality Strategy target. No AlohaCare or 'Ohana rates met the MQD Quality Strategy targets.

HSAG validated six performance measures for the QExA plans for HEDIS 2014, which resulted in 30 indicators, 18 of which are displayed below, compared to HEDIS 2013 Medicaid national percentiles. Figure 1-2 shows the QExA plans' performance compared with the national percentiles.

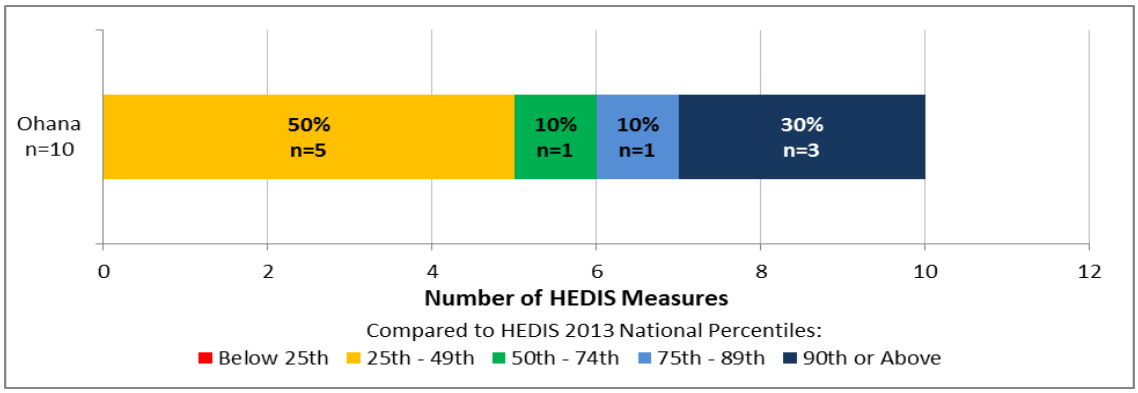
Figure 1-2—Comparison of QExA Plan Indicators to HEDIS Medicaid National Percentiles



Performance between the two QExA plans varied slightly. UHC CP was the better-performing QExA plan with 15 of the 18 rates with available benchmarks for comparison (or 83.3 percent) at or above the HEDIS 2013 national Medicaid 50th percentile. 'Ohana reported 14 of the 18 indicators (or 77.8 percent) at or above the HEDIS 2013 national 50th percentile. UHC CP had 12 indicators meeting the MQD Quality Strategy targets whereas 'Ohana reported 10.

HSAG validated 10 performance measures for the 'Ohana CCS program. These performance measures resulted in 16 rates. 'Ohana CCS received an audit result of NA (small denominator) for five indicators. Of the 11 rates, 10 were compared to the national HEDIS 2013 percentiles. Figure 1-3 shows 'Ohana's CCS performance compared with the national percentiles.

Figure 1-3—Comparison of 'Ohana's CCS Rates to HEDIS Medicaid National Percentiles



'Ohana's CCS performance was mixed for HEDIS 2014. Half of the HEDIS measures with available benchmarks for comparison ranked above the national HEDIS 2013 50th percentile. Three rates were above the 90th percentile. On the other hand, five rates ranked below the 50th percentile, suggesting opportunities for improvement.

Recommendations for improvement varied across the indicators for each plan type. HSAG recommends that each QUEST, QExA, and CCS plan target the lower-performing measures/indicators for improvement. Each plan should conduct a barrier analysis to determine why performance was low, coupled with data analysis and drill-down evaluations of noncompliant cases.

Validation of Performance Improvement Projects (PIPs)

Description

PIPs are designed as an organized way to assist health plans in assessing their health care processes, implementing process improvements, and improving outcomes of care. In 2014, HSAG validated two PIPs for each of the QUEST, QExA, and CCS health plans, for a total of 16 PIPs. The five QUEST plans were required by the MQD to conduct PIPs related to the *Plan All-Cause Readmissions* (PCR) measure and a second topic to improve the *Comprehensive Diabetes Care* (CDC) HEDIS measure. Both QExA plans also conducted PIPs related to the HEDIS measure on diabetes care. For their second PIP topic, the QExA plans focused on an aspect of obesity care—documentation of body mass index (BMI). This was the first year the CCS program conducted PIPs; its two topics were *Follow-up After Hospitalization for Mental Illness* and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*.

HSAG validated each health plan's 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.

Findings, Conclusions, and Recommendations

Following the review and validation of the plans' 2014 PIPs, HSAG concluded that:

- All health plans performed well in the Design stage. This indicates plans demonstrated the ability to document required information for that stage of their PIPs. The health plans designed scientifically sound studies supported by use of key research principles. The design of the PIPs promoted progression to the next stage of the PIP process.
- All health plans performed well in the Implementation stage. These findings suggest health plans accurately documented a thorough process for analyzing data, identifying barriers, and developing interventions.
- All health plans' PIPs received an overall *Met* validation status.
- The 'Ohana CCS, 'Ohana QExA, and 'Ohana QUEST PIPs had no recommendations from the 2014 validation.

- This was the first year submission for the CCS plans, and the PIPs progressed to including baseline results.
- ‘Ohana and UHC QUEST plans submitted baseline results for the *All-Cause Readmissions* PIP for the 2014 validation. The AlohaCare, HMSA, and Kaiser QUEST plans progressed to reporting Remeasurement 1 results for the *All-Cause Readmissions* PIP. HMSA demonstrated statistically significant improvement in the study indicator result. AlohaCare and Kaiser had increases in the rate of readmissions, a decline in performance.
- For the QUEST *Diabetes Care* PIPs, ‘Ohana and UHC reported baseline results and AlohaCare, HMSA, and Kaiser reported first remeasurement results for the 2014 validation. Kaiser achieved statistically significant improvement for its study indicator. AlohaCare had improvement that was not statistically significant in two of four study indicators, and HMSA had improvement that was not statistically significant in one of three study indicators.
- The UHC QExA BMI PIP reported Remeasurement 3 results in the 2014 submission. Both study indicators demonstrated statistically significant and sustained improvement. The ‘Ohana QExA BMI PIP reported Remeasurement 2 results in the 2014 submission. One study indicator demonstrated sustained improvement and the other two study indicators achieved statistically significant improvement. For the study indicators that achieved statistically significant improvement for the 2014 validation, another measurement period result is required to assess for sustained improvement.
- The UHC QExA *Diabetes Care* PIP reported Remeasurement 3 results. Both study indicators demonstrated improvement that was not statistically significant. The health plan has not yet achieved statistically significant improvement over baseline for this PIP. The ‘Ohana QExA *Diabetes Care* PIP reported Remeasurement 4 results. All three study indicators demonstrated statistically significant improvement over baseline for the 2014 validation and one study indicator achieved sustained improvement. For the study indicators that achieved statistically significant improvement for the 2014 validation, another measurement period result is required to assess for sustained improvement.

The health plans that did not have improvement in all study indicators for the 2014 validation received the recommendation to implement strategies to improve performance. The health plans should regularly evaluate interventions to ensure they are having the desired effects. If a health plan’s evaluation of interventions and/or review of data indicates that interventions are not having the desired effects, it should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions, as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

Other recommendations HSAG made were to correct inaccuracies or inconsistencies documented in the PIP forms.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Plan-Specific Adult Survey and Statewide CHIP Survey

Description

The CAHPS health plan surveys are standardized survey instruments which measure members' satisfaction levels with their health care. For 2014, HSAG administered the CAHPS 5.0H Adult Medicaid Health Plan Survey to Medicaid members of the QUEST and QExA plans who met age and enrollment criteria. In addition, HSAG administered the CAHPS 5.0H Child Medicaid Survey (without the Children with Chronic Conditions [CCC] measurement set), via a statewide sampling methodology, to Hawaii's CHIP-eligible enrollees who met age and enrollment criteria. Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan and/or State level CAHPS data.

For each survey, the results of 11 measures of satisfaction were reported. These measures included four global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and five composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*). In addition, two individual items were assessed (*Coordination of Care* and *Health Promotion and Education*).

Findings, Conclusions, and Recommendations

For the QUEST plans and the statewide QUEST aggregate scores as compared to the 2013 NCQA national adult Medicaid average, the following results were noted:[1-5]

- The QUEST aggregate scores were above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care.*
- AlohaCare scored above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Coordination of Care*.
- HMSA scored above the NCQA national adult Medicaid average on none of the nine comparable measures.
- Kaiser scored above the NCQA national adult Medicaid average on seven of the nine comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.
- 'Ohana scored above the NCQA national adult Medicaid average on two of the nine comparable measures: *How Well Doctors Communicate* and *Coordination of Care.*
- UHC CP scored above the NCQA national adult Medicaid average on two of the nine comparable measures: *Rating of All Health Care* and *Coordination of Care.*

[1-5] Due to changes to the *Shared Decision Making* composite measure and the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for these CAHPS measures; thus, comparisons could not be performed for 2014.

Figure 1-4 depicts the top-box scores for the statewide QUEST aggregate and the 2013 NCQA national adult Medicaid average for each of the global ratings.

Figure 1-4—QUEST Aggregate: Global Ratings

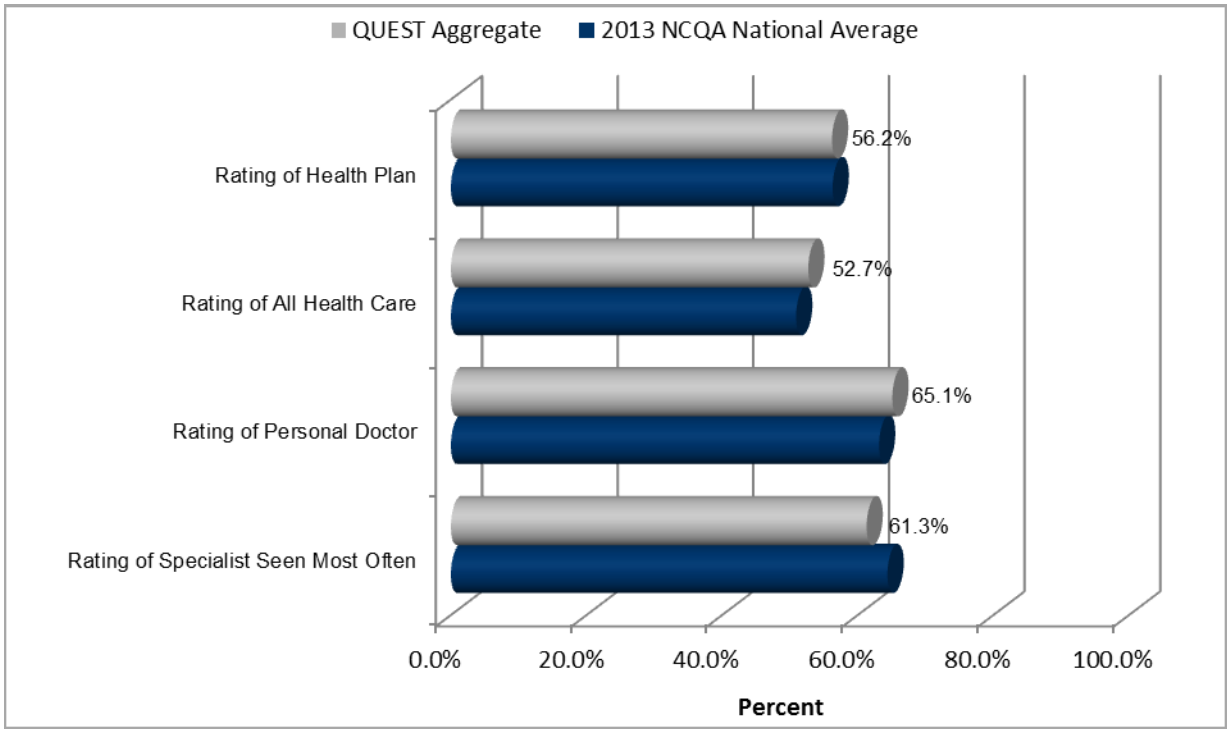
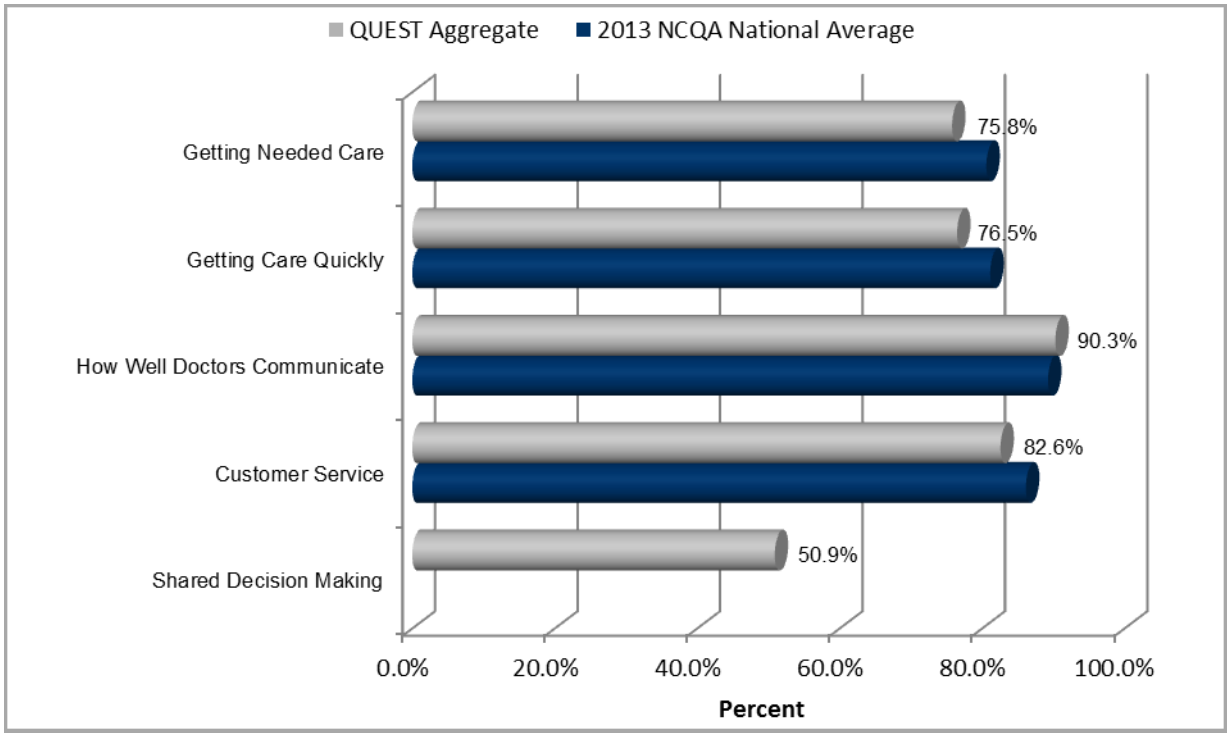


Figure 1-5 depicts the top-box scores for the statewide QUEST aggregate and the 2013 NCQA national adult Medicaid average for each of the composite measures.

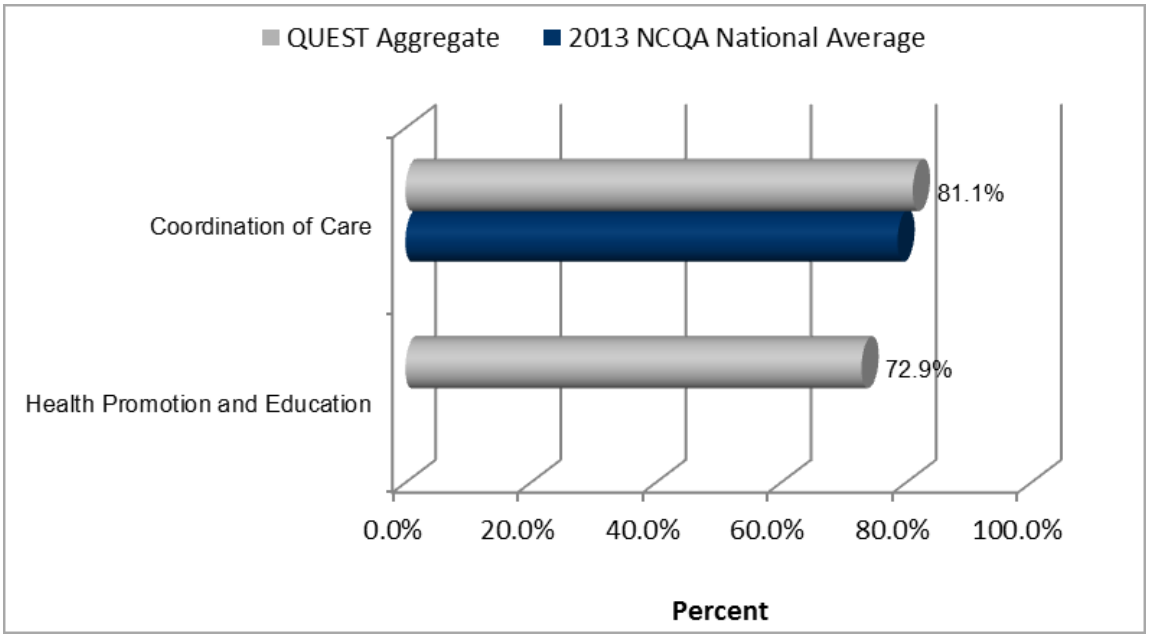
Figure 1-5—QUEST Aggregate: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

Figure 1-6 depicts the top-box scores for the statewide QUEST aggregate and the 2013 NCQA national adult Medicaid average for each of the individual item measures.

Figure 1-6—QUEST Aggregate: Individual Item Measures



Please note: Due to changes to the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

For the QExA plans and the statewide QExA aggregate scores as compared to the 2013 NCQA national adult Medicaid average, the following results were noted:

- The QExA aggregate scores were above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Coordination of Care.*
- 'Ohana scored above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Customer Service*, and *Coordination of Care.*
- UHC CP scored above the NCQA national adult Medicaid average on five of the nine comparable measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Coordination of Care.*

Figure 1-7 depicts the top-box scores for the statewide QExA aggregate and the 2013 NCQA national adult Medicaid average for each of the global ratings.

Figure 1-7—QExA Aggregate: Global Ratings

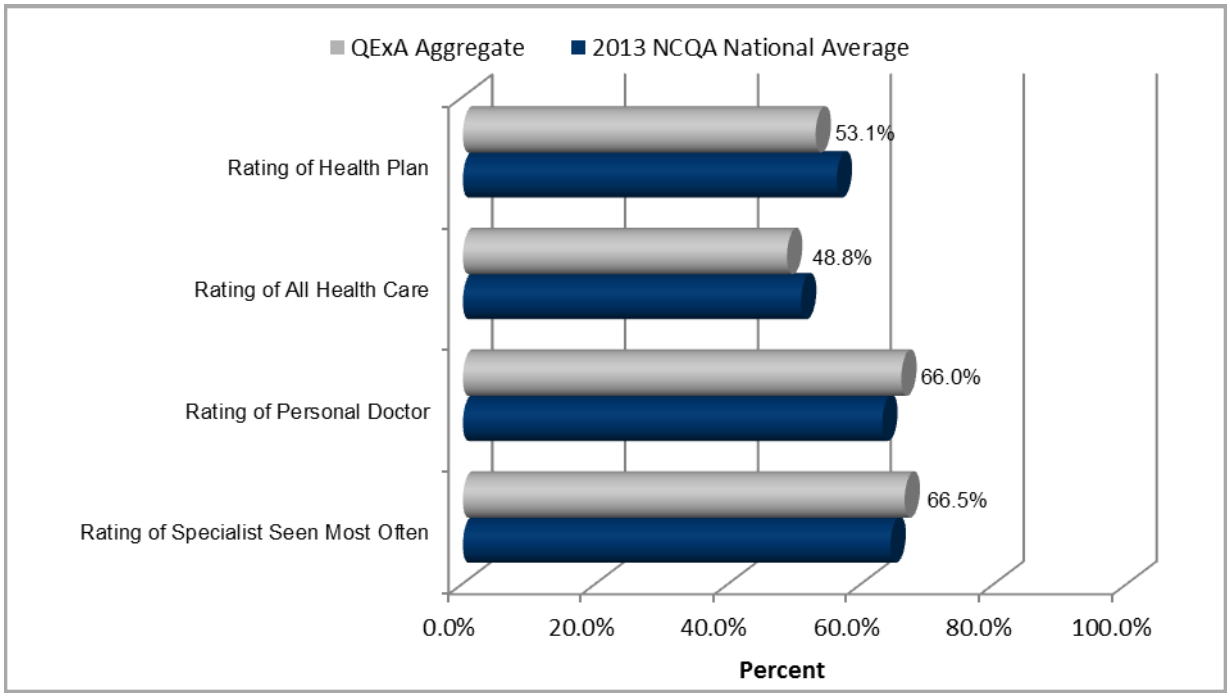
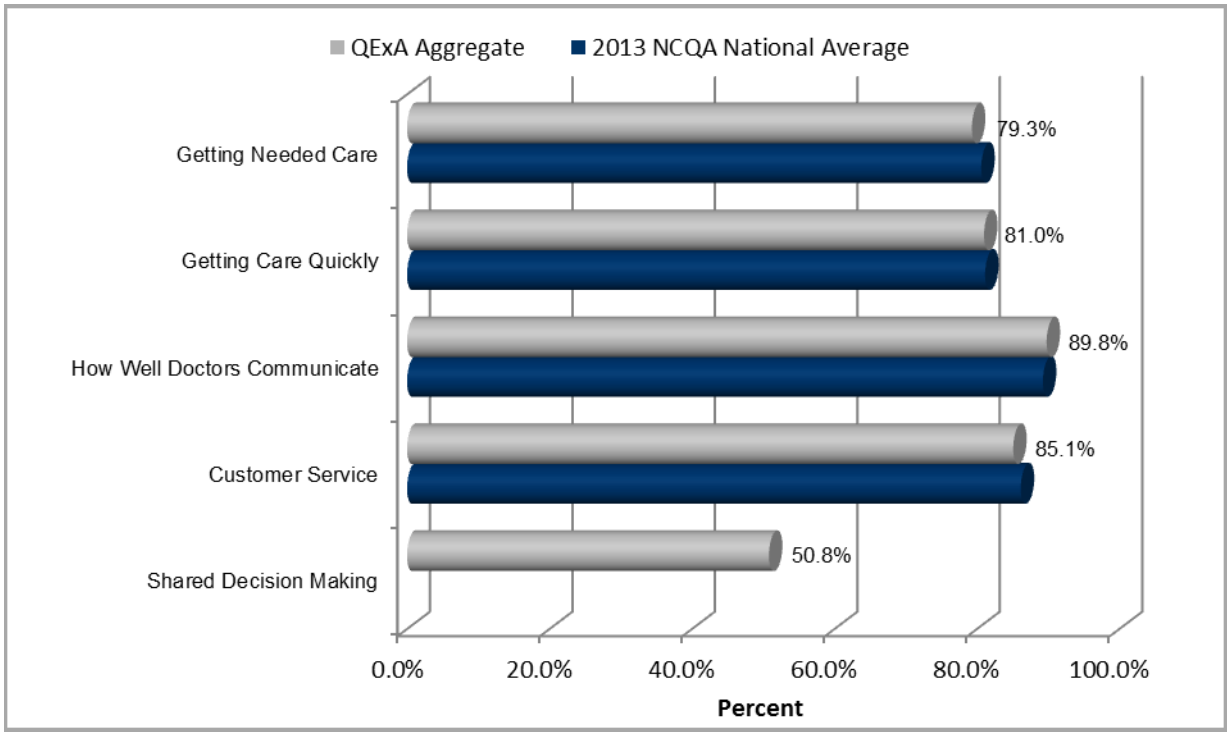


Figure 1-8 depicts the top-box scores for the statewide QExA aggregate and the 2013 NCQA national adult Medicaid average for each of the composite measures.

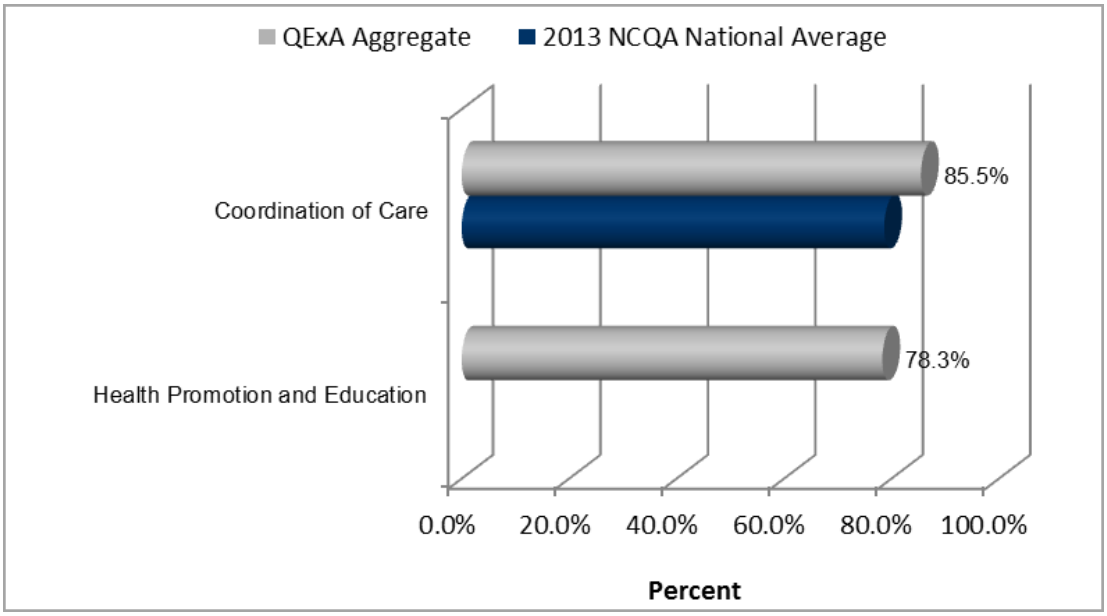
Figure 1-8—QExA Aggregate: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

Figure 1-9 depicts the top-box scores for the statewide QExA aggregate and the 2013 NCQA national adult Medicaid average for each of the individual item measures.

Figure 1-9—QExA Aggregate: Individual Item Measures



Please note: Due to changes to the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

HSAG provided both the QUEST and QExA health plans recommendations related to these findings for each measure considered a "key driver" of member satisfaction.

As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparative purposes. As compared to the 2013 NCQA national child Medicaid average, the following results were noted for the CHIP population:

- CHIP scored above the NCQA national child Medicaid average on four of the nine comparable measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care.*

Figure 1-10 depicts the top-box scores for CHIP and the 2013 NCQA national child Medicaid average for each of the global ratings.

Figure 1-10—CHIP: Global Ratings

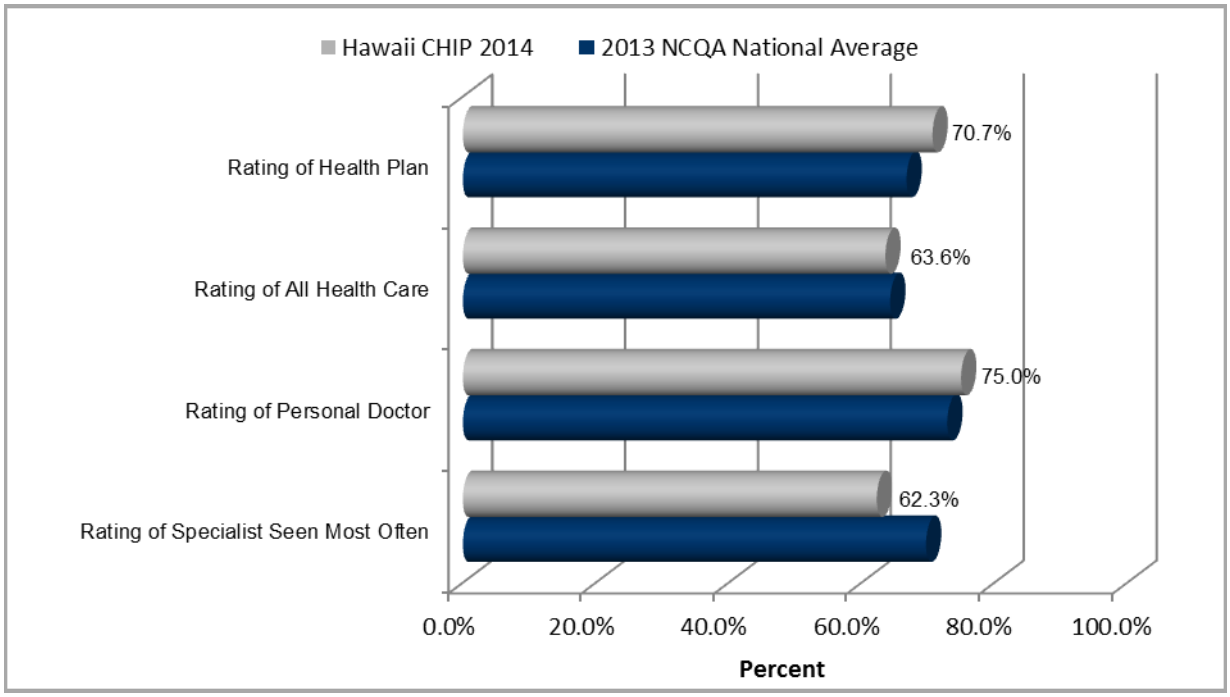
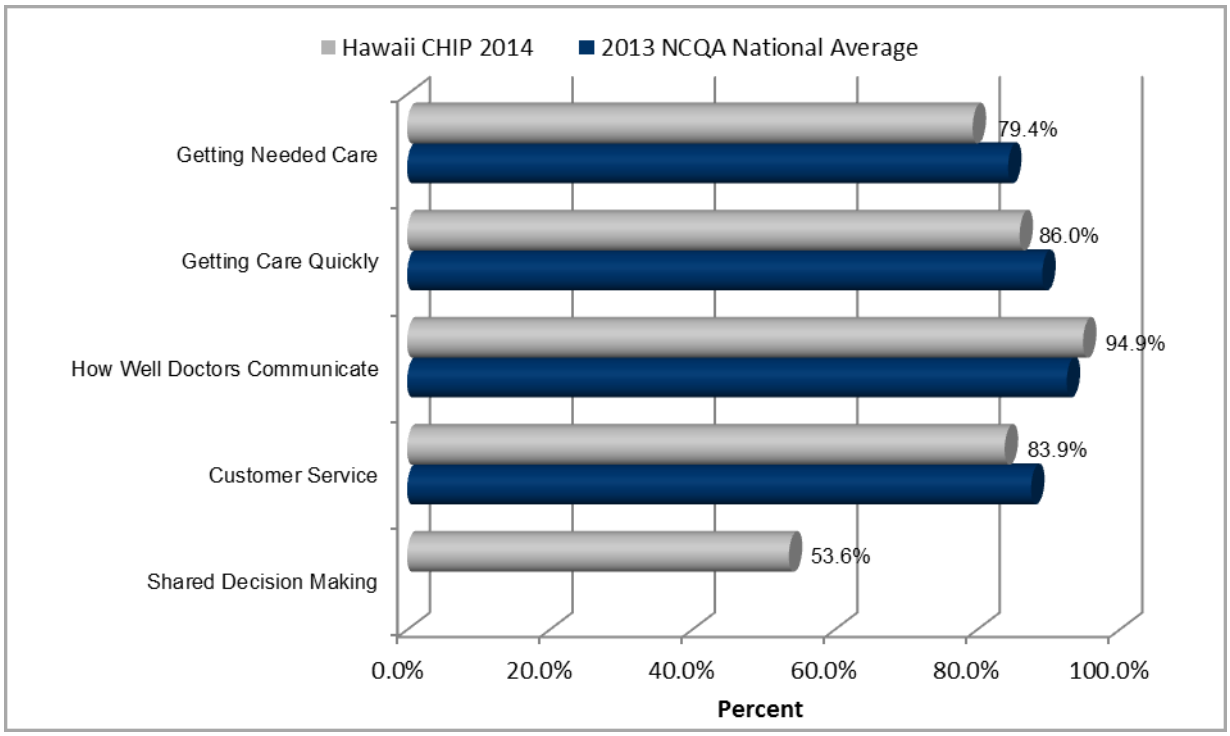


Figure 1-11 depicts the top-box scores for CHIP and the 2013 NCQA national child Medicaid average for each of the composite measures.

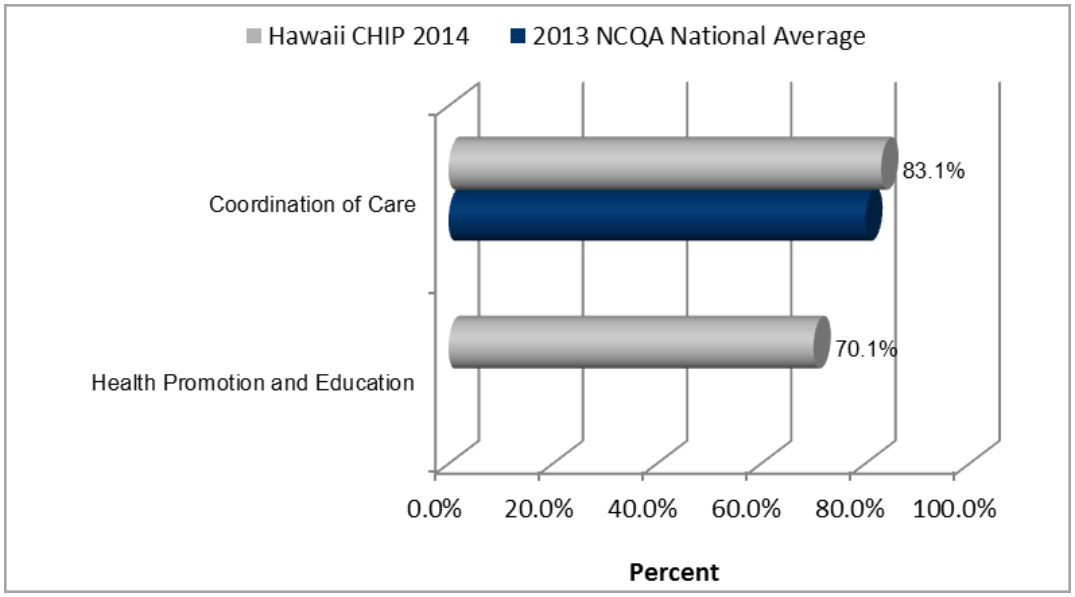
Figure 1-11—CHIP: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

Figure 1-12 depicts the top-box scores for the statewide CHIP aggregate and the 2013 NCQA national child Medicaid average for each of the individual item measures.

Figure 1-12—CHIP: Individual Item Measures



Please note: Due to changes to the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

HSAG provided the MQD general recommendations related to these findings for each measure considered a "key driver" of member satisfaction.

Overview of the Hawaii Medicaid Service Delivery System

The Hawaii Medicaid Program

Medicaid covers more than 315,000[2-1] individuals in the State of Hawaii. The MQD, the division of the Department of Human Services responsible for the overall administration of the State's Medicaid managed care program, has as its mission statement, "To develop and administer high-quality health care programs serving all eligible Hawaii residents." The Hawaii QUEST program is designed to provide:

Q uality care, ensuring
U niversal access, encouraging
E fficient utilization,
S tabilizing costs, and
T ransforming the way health care is provided to public clients.

Hawaii's Medicaid program currently employs two main program types for the delivery of health care services to two major groups of Medicaid recipients in the State. Most Medicaid recipients, over 264,000 individuals, receive primary and acute care service coverage through the Hawaii QUEST program, a managed care model operating under an 1115 research and demonstration waiver since 1994. The QUEST population also includes the State's Child Health Insurance Program (CHIP) population as a Medicaid expansion program. Since February 1, 2009, Medicaid-eligible individuals 65 years of age and older and individuals certified as blind or disabled were enrolled in Hawaii's QExA Medicaid managed care program, receiving primary and acute services as well as long term care services and supports. The QExA program now includes more than 51,000 individuals statewide.

During 2014, QUEST (primary and acute) recipients received covered health care and services through one of five State-contracted health plans: AlohaCare, HMSA, Kaiser, 'Ohana, and UHC CP. Recipients eligible for and enrolled in the QExA program received covered services through one of two QExA health plans: 'Ohana and UHC CP. Hawaii's Medicaid program gives eligible members a choice of at least two managed care health plans on each of the six main islands.

Since March 1, 2013, specialty behavioral health services for QExA-enrolled individuals with a serious mental illness have been provided by the State's Community Care Services (CCS) behavioral health program, a contract awarded to 'Ohana Health Plan.

[2-1] All Medicaid enrollment statistics cited in this section are as of September 2014, as cited in *2014 Medicaid Enrollment.* Available at: http://www.med-quest.us/PDFs/queststatistics/2014%20QUEST%20Enrollment.pdf . Accessed on: September 30, 2014.

While each of the QUEST and QExA health plans also has at least one other line of health insurance business (e.g., Medicare, commercial), the focus of this report is on the health plans' performance and outcomes for the Medicaid-eligible population.

The QUEST and QExA Health Plans

AlohaCare

AlohaCare is a nonprofit health plan founded in 1994 by Hawaii's community health centers. As one of the largest health plans in Hawaii, and administering both Medicaid and Medicare health plan products, AlohaCare QUEST serves over 65,000 Medicaid enrollees. AlohaCare contracts with a large network of providers statewide, emphasizing prevention and primary care. AlohaCare works closely with 14 community health centers to support the needs of the underserved, medically fragile members of Hawaii's communities on the islands of Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu.

Hawaii Medical Service Association (HMSA)

HMSA, an independent licensee of the Blue Cross and Blue Shield Association, is a nonprofit health plan established in Hawaii in 1938. Administering Medicaid, Medicare, and commercial health plans, HMSA is the largest provider of health care coverage in the State and the largest QUEST plan, serving over 145,000 enrolled Medicaid members. More than 95 percent of Hawaii's doctors, hospitals, and other providers participate in HMSA's network. HMSA has been a Medicaid contracted health plan since 1994 and currently serves Medicaid members on the islands of Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu.

Kaiser Permanente Hawaii

Established by Henry J. Kaiser in Honolulu in 1958, Kaiser's service delivery in the Hawaii region is based on a relationship between the Kaiser Permanente Health Plan and the Hawaii Permanente Medical Group of physicians and specialists. With its largely "staff-model" approach, Kaiser operates clinics throughout the islands and a medical center on Oahu. Additional hospitals and specialists participate in Kaiser's network through contract arrangements. Kaiser administers Medicaid, Medicare, and commercial health plans, and provides care to more than 24,000 enrolled Medicaid members on the islands of Maui and Oahu.

'Ohana

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc., a subsidiary of WellCare Health Plans, Inc., which provides managed care services exclusively for government-sponsored health care programs, focusing on Medicaid and Medicare. 'Ohana began operating in Hawaii on February 1, 2009, initially as a QExA plan, then in July of 2012 as a QUEST plan. 'Ohana Health Plan currently provides services to more than 27,000 aged, blind, and disabled QExA enrollees and to over 16,000 QUEST members on the islands of Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu.

UnitedHealthcare Community Plan

UHC CP is offered by UnitedHealthcare Insurance Company. UHC CP administers Medicaid, Medicare, and commercial health plans and, in Hawaii, provides care to more than 24,000 aged, blind, and disabled Medicaid enrollees (QExA) and to nearly 15,000 QUEST members. UHC CP began operating as a QExA health plan in Hawaii on February 1, 2009, and as a QUEST plan on July 1, 2012. UHC CP provides QUEST and QExA services on the islands of Hawaii, Kauai, Lanai, Maui, Molokai, and Oahu.

The Community Care Services Program

In March of 2013, 'Ohana Health Plan became operational as the State's Community Care Services (CCS) behavioral health program, serving seriously mentally ill Medicaid recipients enrolled in the two QExA plans ('Ohana and UHC CP). The CCS program is a specialty behavioral health services "carve-out" program with responsibilities for care management and coordination of behavioral health services with the QUEST and QExA plans' services and providers.

The State's Quality Strategy

In 2010, the MQD developed, and CMS approved, a comprehensive quality strategy for the State's Medicaid program that incorporated the Institute of Medicine (IOM) quality framework for safe, efficient, effective, patient-centered, timely, and equitable care. The core requirements of this quality strategy continued to be in effect during 2014, while undergoing revisions and updates by the MQD to address program changes. The strategy contains guiding principles for ensuring a high-quality care delivery system that includes collaborative partnerships, patient-centered medical homes, transparency, data-driven analysis and monitoring, and quality-based purchasing. In keeping with these principles, this 2014 Hawaii External Quality Review Report of Results provides data analysis, outcomes of monitoring, a mechanism for public reporting and transparency, and validated health plan performance information that the MQD and the health plans can use to further the State's quality strategy goals.

Examples of initiatives undertaken by the MQD as part of this quality strategy over the past year include:

- Requiring optional as well as mandatory activities in HSAG's scope of work as EQRO for the State of Hawaii Medicaid program: compliance monitoring and corrective action follow-up, performance measure validation and HEDIS audits, validation of performance improvement projects, adult CAHPS survey and an additional CHIP member survey, and technical assistance to the MQD and health plans.
- Continually promoting transparency and empowering member involvement in health plan choice by publicly posting health plan performance evaluations, including EQRO results, consumer guides for members, and other reports on the MQD Web site and within enrollment materials.
- Using monitoring results and data to analyze and trend performance of the Medicaid program and to provide monetary incentives for performance that meets or exceeds goals, as measured by

select HEDIS and CAHPS performance indicators. The CY 2013 HEDIS results (validated in 2014) and CAHPS 2014 results will be used for these incentives for the health plans.

- Implementing its Non-duplication Strategy as described in the MQD's Quality Strategy. This process grants "deemed compliance" status to plans that have both achieved NCQA accreditation and fully met those NCQA standards duplicative of the State's standards and federal managed care requirements in select areas. This year, deemed compliance was granted for a set of standards in the areas of credentialing and practice guidelines and is further described in Appendix B of this report.
- Including the CCS program (a prepaid inpatient health plan) in all mandatory EQR activities and requesting HSAG to provide the plan technical assistance to ensure its successful participation in the activities.
- Incorporating review elements into HSAG's health plans compliance monitoring review process to evaluate the plans' implementation of the provider disclosure requirements under the Affordable Care Act. This on-site evaluation, although not scored as part of the overall compliance review score, provided information to the MQD about the plans' degree of implementation of the disclosure requirements. The plans were required to implement corrective action plans (CAPs) for any identified deficiencies and the results of the CAP reevaluation will assist the State in identifying further technical assistance needs.

HSAG also gave the MQD input and recommendations on State-level improvement strategies. As a result, the MQD:

- Continues to annually review and revise, as needed, the sets of HEDIS measures required for reporting by QUEST and QExA plans and validation by HSAG to more closely address the ages and health conditions of the populations and to better align with the CMS core measurement sets for the adult and child Medicaid populations and the State's quality goals. In addition, HSAG provided technical assistance to the MQD and to the 'Ohana CCS program regarding the set of behavioral health performance measures to be collected and reported. HSAG assisted with customizing the measure specifications for one of the measures (Behavioral Health Assessment) to align with the CCS program requirements.
- Requested that HSAG conduct technical assistance and training on HEDIS measures for its MQD staff that monitor and interface with the health plans. This training was conducted in July 2014 and included several modules which provided the MQD staff with information on the HEDIS audit process, development of measures, data sources for measures, and rate analysis and trending. Actual results from HEDIS 2014 audits were used in the presentation, affording the MQD staff a better understanding of the current health plans' performance levels.
- Identified as an opportunity for improvement the plans' low compliance review results for grievance and appeal processing. The MQD is developing and will be implementing standardized forms and letter templates to address issues with clarity, accuracy, and completeness of health plan correspondence to members related to health plan grievance and appeal decisions and member rights. MQD requested technical assistance from HSAG for review of the templates prior to MQD's seeking health plan input.

As part of its overall improvement strategy, the MQD has also progressed with its realignment effort for the entire Medicaid program. In the summer of 2013, the MQD released a competitive procurement for health plans interested in contracting to provide "QUEST Integration" services.

The QUEST Integration (QI) program is a melding of several programs including the QUEST, QUEST-ACE, QUEST-Net, and QExA programs into one statewide program providing managed care services to Hawaii's Medicaid/CHIP population. The goals of the QUEST Integration program are to:

- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating programs and benefits.
- Align the program with the Affordable Care Act (ACA).
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCPs).
- Expand access to home and community based services (HCBS) and allow members choices 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 State, the health plans, and health care providers.
- Continue the predictable and slower rate of expenditure growth associated with managed care.
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to a more appropriate utilization of the health care system.

The MQD awarded QI program contracts to five health plans:

- AlohaCare
- Hawaii Medical Service Association (HMSA)
- Kaiser Foundation Health Plan
- 'Ohana Health Plan
- UnitedHealthcare Community Plan

All health plans will be providing services to QUEST Integration members statewide (i.e., on all islands) except Kaiser Foundation Health Plan, which chose to focus efforts on the islands of Oahu and Maui. The health plans will begin provision of services to QUEST Integration (QI) members on January 1, 2015. Since the awards announcement, the MQD has engaged in multiple activities with the newly awarded QI health plans to assess "readiness" to begin operating on schedule. These activities have included extensive desk reviews of health plan policies, procedures, manuals, member materials, etc., and on-site readiness reviews (beginning in August 2014) of each plan's operations.

3. Plan-Specific Results, Conclusions, and Recommendations

Introduction

This section of the report describes the results of HSAG's 2014 EQR activities and its conclusions as to the strengths and weaknesses of each health plan and the quality and timeliness of, and access to, care furnished by the Hawaii Medicaid health plans serving the QUEST and QExA members. Additionally, recommendations are offered to each plan to facilitate continued quality improvement in the Medicaid program.

Appendix A of this report contains detailed information about the methodologies used to conduct the 2014 EQR activities. It also includes the objectives, technical methods of data collection and analysis, descriptions of data obtained, and descriptions of scoring terms and methods. In addition, a complete, detailed description of each activity conducted and the results obtained appear in the individual activity reports prepared by HSAG for each health plan and the MQD.

Compliance Monitoring Review

The 2014 compliance monitoring review activity included reviews of each health plan's compliance with a set of federal managed care regulations and related MQD contract requirements. This review was the second in a three-year cycle of compliance evaluations for the QUEST and QExA plans, focused on the remaining half of the required standard areas, and was the first EQRO compliance review for the new CCS program. The six standard areas assessed the health plans' processes and performance in selecting providers, subcontracting for services and delegating managed care functions, credentialing providers, implementing quality assessment and performance improvement processes, maintaining a health information system to support quality program and managed care functions, and adopting relevant practice guidelines. In addition, HSAG assessed the degree to which the health plans had implemented new Affordable Care Act requirements related to obtaining provider disclosure information. While this additional area was not subject to scoring, the findings were used to determine corrective actions to be required of the plans and any potential need for technical assistance from the MQD.

HSAG performed the compliance reviews by conducting both a pre-visit desk review of documentation furnished by each plan and an on-site visit at each health plan. Representatives of the MQD accompanied HSAG during all on-site review activities. The results of the compliance reviews were documented in plan-specific reports to create a permanent record of how each health plan performed. Any deficiencies in meeting standards were captured in a corrective action plan (CAP) document provided to each plan with its final report. Following review and approval of each submitted CAP, the MQD and HSAG will perform follow-up monitoring with each health plan to ensure deficiencies are resolved and full compliance is achieved. Following are summaries of each health plan's compliance review results.

AlohaCare

Results

AlohaCare's scores from HSAG's 2014 compliance review are displayed in Table 3-1:

Table 3-1—Standards and Compliance Scores

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Not Scored	Total Compliance Score
I	Provider Selection	8	7	7	0	0	1	0	100%
II	Subcontracts and Delegation	11	11	10	1	0	0	0	95%
III	Credentialing	27	24	24	0	0	0	3*	100%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	0	100%
V	Health Information Systems	6	6	6	0	0	0	0	100%
VI	Practice Guidelines	5	5	5	0	0	0	0	100%
	Totals	**63**	**59**	**58**	**1**	**0**	**1**	**3***	**99%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met t*o the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

***** Although the three Provider Disclosure elements in Standard III were not scored, the plan did not fully meet these requirements and, therefore, will be required to develop and implement a corrective action plan. The requirements (Standard III, #25, #26, and #27) were determined to be "*Partially Met.*"

Conclusions and Recommendations

AlohaCare was found to be compliant with 100 percent of the standards related to Provider Selection, Quality Assessment and Performance Improvement, Health Information Systems, and Practice Guidelines. The health plan demonstrated that it had policies, processes, systems, and staff to fulfill the federal managed care and State contract requirements in these areas.

AlohaCare received recommendations and was required to implement corrective actions in the areas of Subcontracts and Delegation, and Credentialing. AlohaCare should:

- Develop and implement an effective mechanism for tracking all subcontracts/agreements (with providers, delegates, and other health plan vendors) to ensure that its desired agreements do not lapse and that all required subcontract provisions are executable by the health plan.
- Follow its policies and processes for ongoing monitoring of subcontractors' performance.
- Ensure that the processes between the Provider Relations and Quality Improvement departments are well coordinated, as contract renewal cycles and recredentialing cycles will differ. As current contracts are renewed, they should be amended to include disclosure and business transaction requirements.
- Ensure that its disclosure form includes fields to collect all required information.

HMSA

Results

HMSA's scores from HSAG's 2014 compliance review are displayed in Table 3-2:

Table 3-2—Standards and Compliance Scores

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Not Scored	Total Compliance Score
I	Provider Selection	8	7	7	0	0	1	0	100%
II	Subcontracts and Delegation	11	11	11	0	0	0	0	100%
III	Credentialing	4	1	1	0	0	0	3*	100%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	0	100%
V	Health Information Systems	6	6	6	0	0	0	0	100%
VI	Practice Guidelines	5	5	5	0	0	0	0	100%
	Totals	**40**	**36**	**36**	**0**	**0**	**1**	**3***	**100%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored*.

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met t*o the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

***** The three Provider Disclosure elements in Standard III (#2, #3, and #4) were not scored; however, the plan fully met these requirements.

Conclusions and Recommendations

HMSA was found to be compliant with 100 percent of all federal managed care and State contract requirements in the six standard areas reviewed. The health plan demonstrated that it had policies, processes, systems, and staff to fulfill the federal managed care and State contract requirements in these areas.

HSAG did not provide any recommendations; therefore, HMSA was not required to implement any corrective actions.

Kaiser

Results

Kaiser's scores from HSAG's 2014 compliance review are displayed in Table 3-3:

Table 3-3—Standards and Compliance Scores

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Not Scored	Total Compliance Score
I	Provider Selection	8	7	7	0	0	1	0	100%
II	Subcontracts and Delegation	11	4	3	1	0	7	0	88%
III	Credentialing	4	1	1	0	0	0	3*	100%
IV	Quality Assessment and Performance Improvement	6	6	5	1	0	0	0	92%
V	Health Information Systems	6	6	6	0	0	0	0	100%
VI	Practice Guidelines	5	5	5	0	0	0	0	100%
	Totals	40	29	27	2	0	8	3*	97%

Total # of Elements: The total number of elements in each standard.

***Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of* NA *or* Not Scored.**

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of* Met *to the weighted (multiplied by 0.50) number that received a score of* Partially Met*, then dividing this total by the total number of applicable elements.

* Although the three Provider Disclosure elements in Standard III were not scored, the plan did not fully meet these requirements and therefore will be required to develop and implement a corrective action plan. Two requirements (Standard III, #2 and #3) were determined to be "*Not Met*" while the third item (Standard III, #4) was "*Partially Met.*"

Conclusions and Recommendations

Kaiser was found to be compliant with 100 percent of the standards related to Provider Selection, Health Information Systems, and Practice Guidelines. The health plan demonstrated that it had policies, processes, systems, and staff to fulfill the federal managed care and State contract requirements in these areas.

Kaiser received recommendations and was required to implement corrective actions in the areas of Subcontracts and Delegation, Credentialing, and Quality Assessment and Performance Improvement. Kaiser should:

- Ensure that its agreements with providers and subcontractors include the requirements and time frames for notifying the health plan and the MQD of all breaches of confidential information.
- Ensure that it documents and implements a process and procedures to ensure that credentialing, recredentialing, and contracting activities meet the requirements to obtain full disclosure statements and business transaction disclosures as required from its providers.
- Provide disclosure information to the MQD in the format and with the periodicity required.
- Ensure that its disclosure form includes fields to collect all required information.
- Implement mechanisms for ensuring that QUEST-specific requirements are included and accurately represented in its QI and UM program descriptions and work plans.

‘Ohana

Results

‘Ohana’s scores from HSAG’s 2014 compliance review are displayed in Table 3-4, Table 3-5, and Table 3-6. Separate scores were calculated for ‘Ohana’s QUEST and QExA lines of business and for the new ‘Ohana CCS program:

Table 3-4—Standards and Compliance Scores—QUEST

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Not Scored	Total Compliance Score
I	Provider Selection	8	7	7	0	0	1	0	100%
II	Subcontracts and Delegation	11	11	11	0	0	0	0	100%
III	Credentialing	4	1	1	0	0	0	3*	100%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	0	100%
V	Health Information Systems	6	6	6	0	0	0	0	100%
VI	Practice Guidelines	5	5	5	0	0	0	0	100%
	Totals	40	36	36	0	0	1	3*	100%

Table 3-5—Standards and Compliance Scores—QExA

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Not Scored	Total Compliance Score
I	Provider Selection	8	7	7	0	0	1	0	100%
II	Subcontracts and Delegation	11	11	11	0	0	0	0	100%
III	Credentialing	4	1	1	0	0	0	3*	100%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	0	100%
V	Health Information Systems	6	6	6	0	0	0	0	100%
VI	Practice Guidelines	5	5	5	0	0	0	0	100%
	Totals	40	36	36	0	0	1	3*	100%

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

* Although the three Provider Disclosure elements in Standard III were not scored, the plan did not fully meet these requirements and therefore will be required to develop and implement a corrective action plan. The requirements (Standard III, #2, #3, and #4) were determined to be “*Partially Met.*”

Table 3-6—Standards and Compliance Scores—CCS									
Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Not Scored	Total Compliance Score
I	Provider Selection	8	7	7	0	0	1	0	100%
II	Subcontracts and Delegation	11	11	11	0	0	0	0	100%
III	Credentialing	4	1	1	0	0	0	3*	100%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	0	100%
V	Health Information Systems	6	6	6	0	0	0	0	100%
VI	Practice Guidelines	5	5	5	0	0	0	0	100%
	Totals	**40**	**36**	**36**	**0**	**0**	**1**	**3***	**100%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met t*o the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

* Although the three Provider Disclosure elements in Standard III were not scored, the plan did not fully meet these requirements and therefore will be required to develop and implement a corrective action plan. The requirements (Standard III, #2, #3, and # 4) were determined to be "*Partially Met.*"

Conclusions and Recommendations

'Ohana maintained standardized administrative policies and processes for the areas under review for its QUEST and QExA programs as well as its CCS program. Because of the similarities in processes, HSAG's conclusions and recommendations presented here are relevant for all three programs.

'Ohana was found to be compliant with 100 percent of the standards related to Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance Improvement, Health Information Systems, and Practice Guidelines. The health plan demonstrated that it had policies, processes, systems, and staff to fulfill the federal managed care and State contract requirements in these areas.

'Ohana received recommendations and was required to implement corrective actions in the area of Credentialing, specifically for the standards related to provider disclosure requirements. 'Ohana should:

- Implement a process to obtain completed disclosure statements from all applicants as part of the credentialing and recredentialing processes as well as upon contract execution/renewal.

UnitedHealthcare Community Plan

Results

UHC CP's scores from HSAG's 2014 compliance review are displayed in Table 3-7 and Table 3-8. Separate scores were calculated for UHC CP's QUEST and QExA lines of business:

Table 3-7—Standards and Compliance Scores—QUEST

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Not Scored	Total Compliance Score
I	Provider Selection	8	7	7	0	0	1	0	100%
II	Subcontracts and Delegation	11	11	11	0	0	0	0	100%
III	Credentialing	4	1	1	0	0	0	3	100%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	0	100%
V	Health Information Systems	6	6	6	0	0	0	0	100%
VI	Practice Guidelines	5	5	5	0	0	0	0	100%
	Totals	40	36	36	0	0	1	3*	100%

Table 3-8—Standards and Compliance Scores—QExA

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Not Scored	Total Compliance Score
I	Provider Selection	8	7	7	0	0	1	0	100%
II	Subcontracts and Delegation	11	11	11	0	0	0	0	100%
III	Credentialing	4	1	1	0	0	0	3	100%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	0	100%
V	Health Information Systems	6	6	6	0	0	0	0	100%
VI	Practice Guidelines	5	5	5	0	0	0	0	100%
	Totals	40	36	36	0	0	1	3*	100%

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA* or *Not Scored.*

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met t*o the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

***** The three Provider Disclosure elements in Standard III (#2, #3, and #4) were not scored; however, the plan fully met these requirements.

Conclusions and Recommendations

UHC CP maintained standardized administrative policies and processes for the areas under review for its QUEST and QExA programs. Because of the similarities in processes, HSAG's conclusions and recommendations presented here are relevant for both programs.

UHC CP was found to be compliant with 100 percent of all federal managed care and State contract requirement in the six standard areas reviewed. The health plan demonstrated that it had policies, processes, systems, and staff to fulfill the federal managed care and State contract requirements in these areas.

HSAG did not provide any recommendations; therefore, UHC CP was not required to implement any corrective actions.

Validation of Performance Measures—HEDIS Compliance Audits

This section reports results of the 2014 HEDIS compliance audits and performance measure validation for the QUEST, QExA, and CCS health plans. Also presented in this section are the actual performance measure rates attained by each QUEST and QExA health plan on the required performance measures validated by HSAG, with comparisons to the HEDIS 2013 Medicaid percentiles and to the previous year's rates, where applicable. For the CCS program, HSAG validated 10 performance measures. The HEDIS and performance measure rates validated by HSAG represented calendar year (CY) 2013 data.

The QUEST and QExA health plan results tables show the current year's performance for each HEDIS measure compared to the prior year's rate, whether or not the measure met the MQD Quality Strategy target,[3-1] and the performance level relative to the NCQA national Medicaid HEDIS 2013 percentile. The performance level column illustrated in the tables rates the health plans' performance as follows:

★ = Below the national Medicaid 25th percentile
★★ = From the 25th percentile to the 49th percentile
★★★ = From the 50th percentile to the 74th percentile
★★★★ = From the 75th percentile to the 89th percentile
★★★★★ = At or above the 90th percentile

Statistical significance testing was performed between the HEDIS 2013 and HEDIS 2014 rates (i.e., measurement years 2012 and 2013) to determine if the changes in rates from one year to the next were significant. These results are presented in the column, "Percentage Point Change." The percentage point change is presented as a + or -. Statistically significant improvement is represented in **green** and statistically significant decline is represented in **red**.

When calculating HEDIS performance measure rates for their aged, blind, and disabled populations, the two QExA health plans—'Ohana and UHC CP—excluded enrollees who were dually eligible (i.e., enrollees with both Medicaid and Medicare coverage) when the Medicare coverage was through fee-for-service Medicare or an unknown/other Medicare plan. Because these data on Medicare services and encounters would not be readily available to the plans, eliminating this dually-eligible population from the measure calculations reduced the chance of negatively affecting performance measure results. However, members dually enrolled in the plan's Medicaid program and Medicare plan were expected to be included in the rate calculations, which was consistent with the HEDIS specifications.

[3-1] The MQD Quality Strategy targets represent the national HEDIS Medicaid 75th percentile for all QUEST and QExA measures except *Well-Child Visits in the First 15 Months of Life—Zero Visits, Comprehensive Diabetes Care—HbA1c Poor Control (>9.0), Ambulatory Care—ED Visits,* and *Plan All-Cause Readmission,* where lower rates indicate better performance. For these four indicators, the MQD Quality Strategy target is at or below the national HEDIS Medicaid 25th percentile. Although actual percentiles are not shown in this report, in the tables any cells containing rates that met the MQD Quality Strategy targets are shaded in blue.

Table 3-9 presents the QUEST and QExA HEDIS measures included in this report along with their abbreviations and an indication of whether the measure was collected and calculated using an administrative (admin) or hybrid methodology. This was the first year that the 'Ohana QUEST and UHC CP QUEST plans collected and reported performance measures and the first performance measure validation conducted by HSAG for these plans.

Table 3-9—QUEST/QExA Validated HEDIS Measures and Abbreviations

	Measure Name	QUEST	QExA	Methodology
1	*Childhood Immunization Status—Combos 2 through 10 (CIS)*	✓		*Hybrid*
2	*Breast Cancer Screening (BCS)*	✓		*Admin*
3	*Chlamydia Screening in Women (CHL)*	✓		*Admin*
4	*Controlling High Blood Pressure (CBP)*	✓	✓	*Hybrid*
5	*Comprehensive Diabetes Care (CDC)*	✓	✓	*Hybrid*
6	*Well-Child Visits in the First 15 Months of Life (W15)*	✓		*Hybrid*
7	*Adults' Access to Preventive/Ambulatory Health Services (AAP)*		✓	*Admin*
8	*Inpatient Utilization—General Hospital/Acute Care (IPU)*		✓	*Admin*
9	*Ambulatory Care (AMB)*		✓	*Admin*
10	*Plan All-Cause Readmissions (PCR)**		✓	*Admin*

**Because there are no Medicaid specifications for the PCR measure, the MQD required this measure to be reported applying the Medicare weighting tables for the QExA population.*

This was the first year that the 'Ohana CCS program collected and reported performance measures and the first performance measure validation conducted by HSAG for the plan. Table 3-10 presents the CCS HEDIS and non-HEDIS performance measures included in this report along with their abbreviations. All measures were collected and calculated using the administrative methodology. HEDIS measure results were compared to the NCQA national Medicaid percentiles for evaluation. The CCS results will create a baseline of the plan's performance for comparison to future years' results.

Table 3-10—Validated CCS Performance Measures				
	Measure Name	**HEDIS**	**Non-HEDIS**	**Methodology**
1	*Follow-Up After Hospitalization for Mental Illness (FUH)*	✓		*Admin*
2	*Follow-Up with Assigned PCP After Hospitalization for Mental Illness (FUP)*		✓	*Admin*
3	*Behavioral Health Assessment and Follow-Up (BHA)*		✓	*Admin*
4	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*	✓		*Admin*
5	*Mental Health Utilization (MHU)*	✓		*Admin*
6	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*	✓		*Admin*
7	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	✓		*Admin*
8	*Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*	✓		*Admin*
9	*Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)*	✓		*Admin*
10	*Plan All-Cause Readmissions (PCR)**	✓		*Admin*

**Because there are no Medicaid specifications for the PCR measure, the MQD required this measure to be reported applying the Medicare weighting tables for the CCS population.*

AlohaCare's QUEST Performance

HEDIS Compliance Audit

The review team validated AlohaCare's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) AlohaCare was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-11). This demonstrated that AlohaCare had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures.

This was the first year that AlohaCare used Verisk to calculate its HEDIS rates. Appropriate processes were in place to monitor the accuracy and completeness of the file transfer process. Appropriate back-up and security procedures were in place to safeguard data files in the event of a system failure. Primary source verification revealed that the selected measures produced by AlohaCare were prepared according to the 2014 HEDIS specifications.

Although AlohaCare was fully compliant with HEDIS reporting requirements, HSAG suggested that AlohaCare start using the new member contact information at the time it is received directly from the member. Waiting for the information from the 834 files could result in a missed opportunity to contact a member about a needed medical service.

Based on last year's recommendation that AlohaCare increase its vendor oversight with proper monitoring and documentation, for HEDIS 2014 reporting, AlohaCare conducted oversight of its vendor by reviewing both the Verisk training manual (for accuracy) and weekly procurement reports. In addition, AlohaCare overread close to 100 percent of the completed cases to ensure abstraction accuracy.

Table 3-11—AlohaCare: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	IS 2.0 – Enrollment Data	IS 3.0 – Provider Data	IS 4.0 – Medical Record Data	IS 5.0 – Supplemental Data	IS 6.0 – Call Center	IS 7.0 – Data Integration
Fully Compliant	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

Table 3-12 showed that AlohaCare received the audit results of *Report* for its selected measures.

Table 3-12—AlohaCare: HEDIS Compliance Audit Results for Selected Measures					
CIS	W15	CHL	CBP	CDC	BCS
Report	*Report*	*Report*	*Report*	*Report*	*Report*

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURES

AlohaCare's performance on the *Childhood Immunization Status* (CIS) and the *Well-Child Visits* measures for HEDIS 2014 is shown in Table 3-13. Eleven of 19 CIS indicators showed a rate decline and seven showed a rate increase. One indicator reported a significant decline (*Rotavirus*: 7.3 percentage points) and one reported no change from last year's rate. For the *Well-Child Visits in the First 15 Months of Life* measure, AlohaCare reported significant improvement in the *Six or More Visits* category (9.01 percentage points). No measures in this domain met the MQD Quality Strategy targets. Fourteen measures were below the national 25th percentiles, and two were at or above the 50th percentiles but below the 75th percentiles.

Table 3-13—AlohaCare's HEDIS Results for QUEST Measures Under Children's Preventive Care

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Childhood Immunization Status				
DTaP	63.99%	64.23%	+0.24	★
IPV	80.78%	79.81%	-0.97	★
MMR	77.86%	77.13%	-0.73	★
HiB	80.29%	80.29%	0.00	★
Hepatitis B	76.89%	75.43%	-1.46	★
VZV	77.37%	76.16%	-1.21	★
Pneumococcal Conjugate	62.29%	63.26%	+0.97	★
Hepatitis A	72.99%	72.75%	-0.24	★
Rotavirus	61.31%	54.01%	**-7.30**	★
Influenza	47.93%	48.66%	+0.73	★★
Combination #2	60.58%	59.85%	-0.73	★
Combination #3	57.18%	56.69%	-0.49	★
Combination #4	53.28%	53.77%	+0.49	★
Combination #5	44.77%	40.63%	-4.14	★
Combination #6	38.20%	40.88%	+2.68	★★
Combination #7	42.09%	39.66%	-2.43	★
Combination #8	36.25%	40.15%	+3.90	★★★
Combination #9	32.60%	31.63%	-0.97	★★
Combination #10	30.90%	31.39%	+0.49	★★★
Well-Child Visits in the First 15 Months of Life				
0 Visits[€]	1.46%	1.70%	+0.24[€]	★★
6 or More Visits	55.47%	64.48%	**+9.01**	★★

[€] A lower rate indicates better performance for this measure. A positive value in the Percentage Point Change column denotes a decline in performance. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

WOMEN'S HEALTH MEASURES

All three indicators for *Chlamydia Screening in Women* showed significant performance decline of at least 10 percentage points from last year's performance (see Table 3-14). This measure, along with the *Breast Cancer Screening* measure, benchmarked below the national 25th percentiles and did not meet the MQD Quality Strategy targets.

Table 3-14—AlohaCare's HEDIS Results for QUEST Measures Under Women's Health

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Chlamydia Screening in Women				
16–20 Years	55.65%	44.03%	**-11.62**	★
21–24 Years	59.95%	46.93%	**-13.02**	★
Total	57.85%	45.61%	**-12.24**	★
Breast Cancer Screening				
Breast Cancer Screening	--	28.28%	--	★

CARE FOR CHRONIC CONDITIONS

AlohaCare showed performance decline in six rates and improvement in five of the 11 rates, though none of these changes were statistically significant changes (see Table 3-15). Only one rate (*Controlling High Blood Pressure*) reported a change of more than five percentage points. Eleven rates ranked below the national 50th percentiles, nine of which were below the national 25th percentile. None of these rates met the MQD Quality Strategy targets.

Table 3-15—AlohaCare's HEDIS Results for QUEST Measures Under Care for Chronic Conditions

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Controlling High Blood Pressure				
<140/90 mm Hg	48.42%	43.31%	-5.11	★
Comprehensive Diabetes Care				
HbA1c Testing	79.01%	77.78%	-1.23	★
HbA1c Poor Control (>9.0%)[€]	63.32%	59.37%	-3.95[€]	★
HbA1c Control (<8.0%)	29.38%	31.34%	+1.96	★
HbA1c Control (<7.0%)	16.06%	18.26%	+2.20	★
Eye Exam	55.66%	51.08%	-4.58	★★
LDL-C Screening	66.79%	69.65%	+2.86	★
LDL-C Control	25.91%	26.70%	+0.79	★
Nephropathy	73.18%	72.80%	-0.38	★
Blood Pressure Control (<140/80)	35.40%	33.00%	-2.40	★★
Blood Pressure Control (<140/90)	55.66%	51.24%	-4.42	★

[€] A lower rate indicates better performance for this measure. A negative value in the Percentage Point Change column denotes an improvement in performance. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

Conclusions and Recommendations

Overall, AlohaCare continued to have much room for improvement. Compared to HEDIS 2013, four HEDIS 2014 rates reported a statistically significant decline. Of the 36 QUEST rates, 27 ranked below the national HEDIS 2013 Medicaid 25th percentile and only two ranked above the 50th percentile but below the 75th percentile. No rates met the MQD Quality Strategy targets. AlohaCare should continue to ensure that claims and encounter data are complete and accurate and increase the use of supplemental data sources for reporting all QUEST measures.

HMSA's QUEST Performance

HEDIS Compliance Audit

The review team validated HMSA's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) HMSA was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-16). This demonstrated that HMSA had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. Primary source verification showed that the selected measures produced by HMSA were prepared according to the 2014 HEDIS specifications.

This was the first year HMSA used Caremark CVS for pharmacy claims processing. Pharmacy data files were reviewed for data completeness by HMSA's finance department, and HMSA indicated no data integrity issues identified during 2013. In addition, HMSA contracted an independent pharmacy consultant for additional vendor oversight.

Although HMSA was fully compliant with HEDIS reporting requirements, HSAG had a suggestion for future performance measure reporting. Similar to the prior year's recommendation, HMSA should continue its attempt to use new member contact information at the time it is received directly from the member. Waiting for the information from the 834 files could result in a missed opportunity to contact a member about a needed medical service.

Based on last year's recommendation that HMSA should ensure the receipt of laboratory data for rate calculation, HMSA closely monitored its lab data volume for completeness throughout the year, and no concerns were identified during the measurement year.

Table 3-16—HMSA: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	IS 2.0 – Enrollment Data	IS 3.0 – Provider Data	IS 4.0 – Medical Record Data	IS 5.0 – Supplemental Data	IS 6.0 – Call Center	IS 7.0 – Data Integration
Fully Compliant	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

Table 3-17 shows that HMSA received the audit results of *Report* for its selected measures.

Table 3-17—HMSA: HEDIS Compliance Audit Results for Selected Measures					
CIS	W15	CHL	CBP	CDC	BCS
Report	*Report*	*Report*	*Report*	*Report*	*Report*

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURES

HMSA showed rate increase in 12 of the 19 *Childhood Immunization Status* rates, with three showing significant improvement (see Table 3-18). Although six *Childhood Immunization Status* rates showed a decrease from last year, none were significant declines. Both indicators of the *Well-Child Visits in the First 15 Months of Life* measure reported significant increases from last year — both more than five percentage points. Nonetheless, no measures in this domain met the MQD Quality Strategy targets. As a whole, six measures were below the national 25th percentile, nine were at or above the 25th percentile but below the 50th percentile, and six were at or above the 50th percentile but below the 75th percentile.

Table 3-18—HMSA's HEDIS Results for QUEST Measures Under Children's Preventive Care

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Childhood Immunization Status				
DTaP	74.70%	75.18%	+0.48	★
IPV	86.37%	86.86%	+0.49	★
MMR	91.97%	91.00%	-0.97	★★
HiB	89.29%	87.59%	-1.70	★
Hepatitis B	89.54%	89.29%	-0.25	★★
VZV	89.29%	89.54%	+0.25	★★
Pneumococcal Conjugate	73.48%	77.37%	+3.89	★★
Hepatitis A	64.48%	64.48%	0.00	★
Rotavirus	60.34%	58.88%	-1.46	★
Influenza	42.82%	48.66%	+5.84	★★
Combination #2	72.02%	71.78%	-0.24	★★
Combination #3	68.13%	68.37%	+0.24	★★
Combination #4	53.04%	55.72%	+2.68	★
Combination #5	49.64%	48.91%	-0.73	★★
Combination #6	35.77%	42.82%	**+7.05**	★★★
Combination #7	42.34%	44.77%	+2.43	★★
Combination #8	31.39%	38.93%	**+7.54**	★★★
Combination #9	30.66%	35.52%	+4.86	★★★
Combination #10	27.01%	33.33%	**+6.32**	★★★
Well-Child Visits in the First 15 Months of Life				
0 Visits[€]	6.61%	1.15%	**-5.46**[€]	★★★
6 or More Visits	62.93%	70.40%	**+7.47**	★★★

[€] A lower rate indicates better performance for this measure. A negative value in the Percentage Point Change column denotes an improvement in performance. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

WOMEN'S HEALTH MEASURES

Two of the three indicators for *Chlamydia Screening in Women* showed a rate decrease from last year, although only one had a significant decline (see Table 3-19). Three rates met the MQD Quality Strategy targets. Of all rates under Women's Health, three ranked above the national 75th percentile, one of which was above the 90th percentile.

Table 3-19—HMSA's HEDIS Results for QUEST Measures Under Women's Health

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Chlamydia Screening in Women				
16–20 Years	61.17%	61.51%	+0.34	★★★★
21–24 Years	69.33%	66.40%	**-2.93**	★★★
Total	65.40%	64.02%	-1.38	★★★★
Breast Cancer Screening				
Breast Cancer Screening	--	64.69%	--	★★★★★

CARE FOR CHRONIC CONDITIONS

HMSA showed performance decline in four of the 11 rates in this domain, of which two had statistically significant decline (see Table 3-20). For the seven rates that demonstrated performance improvement, only one (*Comprehensive Diabetes Care: Nephropathy*) reported significant improvement. One rate met the MQD Quality Strategy target (*LDL-C Screening*). As a whole, four rates ranked below the national 25th percentile and one above the 75th percentile.

Table 3-20—HMSA's HEDIS Results for QUEST Measures Under Care for Chronic Conditions				
	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Controlling High Blood Pressure				
<140/90 mm Hg	51.58%	45.99%	-5.60	★
Comprehensive Diabetes Care				
HbA1c Testing	80.47%	83.73%	+3.26	★★★
HbA1c Poor Control (>9.0%)[€]	50.18%	49.73%	-0.45[€]	★★
HbA1c Control (<8.0%)	40.69%	42.23%	+1.54	★★
HbA1c Control (<7.0%)	23.95%	27.90%	+3.95	★
Eye Exam	57.30%	57.40%	+0.10	★★★
LDL-C Screening	76.09%	80.80%	+4.71	★★★★
LDL-C Control	34.31%	30.90%	-3.41	★★
Nephropathy	73.54%	79.34%	**+5.80**	★★★
Blood Pressure Control (<140/80)	38.50%	25.78%	**-12.72**	★
Blood Pressure Control (<140/90)	55.11%	41.50%	**-13.61**	★

[€] A lower rate indicates better performance for this measure. A negative value in the Percentage Point Change column denotes an improvement in performance. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

Conclusions and Recommendations

HMSA's HEDIS 2014 performance was mixed, with six rates reporting statistically significant improvement and three significant decline since last year. Twenty-two of the 36 rates ranked below the national HEDIS 2013 Medicaid 50th percentile, 10 of which were below the 25th percentile. Four rates benchmarked above the 75th percentile, with one above the 90th percentile. Four rates met the MQD Quality Strategy targets. Opportunities for improvement existed in *Childhood Immunization Status* and *HbA1c Control* under *Comprehensive Diabetes Care*. HMSA should continue to monitor claims and encounter data completeness and increase the use of supplemental data for reporting.

Kaiser's QUEST Performance

HEDIS Compliance Audit

The review team validated Kaiser's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) Kaiser was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-21). This demonstrated that Kaiser had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures.

Primary source verification was performed, and an issue was identified for the W15 measure. This measure appeared to be using completed telephonic interviews as compliance for well-child visits. Kaiser was required to remove the telephonic interviews and resubmit the source code for approval. The newly submitted source code was validated and approved prior to the final rate submission in June. Furthermore, primary source verification was conducted to examine the blood pressure readings. The readings appeared to be correct compared to the medical record; however, half of the reviewed cases had comorbid conditions and were noted as obese, yet had blood pressure readings as low as 95/55. HSAG recommends that Kaiser conduct internal reviews of some of these cases to ensure accuracy of reporting. All other selected measures were prepared according to the 2014 HEDIS specifications.

Kaiser was found to be *Fully Compliant* with HEDIS reporting requirements; HSAG provided no recommendations for performance measure reporting.

Table 3-21—Kaiser: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	IS 2.0 – Enrollment Data	IS 3.0 – Provider Data	IS 4.0 – Medical Record Data	IS 5.0 – Supplemental Data	IS 6.0 – Call Center	IS 7.0 – Data Integration
Fully Compliant	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

Table 3-22 shows that Kaiser received the audit results of *Report* for its selected measures.

Table 3-22—Kaiser: HEDIS Compliance Audit Results for Selected Measures					
CIS	W15	CHL	CBP	CDC	BCS
Report	*Report*	*Report*	*Report*	*Report*	*Report*

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURE

Kaiser demonstrated rate increase for 16 of the 19 *Childhood Immunization Status* rates, five of which demonstrated significant improvement (see Table 3-23). Although three of the 19 rates showed a decline, the decrease was less than two percentage points. Both indicators of the *Well-Child Visits in the First 15 Months of Life* measure showed a slight but statistically non-significant decline in performance from last year. Overall, 17 rates met the MQD Quality Strategy targets. All rates were above the national 50th percentiles, with 16 above the 90th percentile.

Table 3-23—Kaiser's HEDIS Results for QUEST Measures Under Children's Preventive Care

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Childhood Immunization Status				
DTaP	88.89%	90.47%	+1.58	★★★★★
IPV	95.32%	94.12%	-1.20	★★★
MMR	92.28%	93.90%	+1.62	★★★
HiB	95.20%	94.12%	-1.08	★★★
Hepatitis B	94.27%	94.12%	-0.15	★★★★
VZV	92.28%	93.46%	+1.18	★★★
Pneumococcal Conjugate	86.32%	88.25%	+1.93	★★★★★
Hepatitis A	92.63%	93.57%	+0.94	★★★★★
Rotavirus	77.08%	89.91%	**+12.83**	★★★★★
Influenza	82.46%	84.15%	+1.69	★★★★★
Combination #2	87.13%	88.91%	+1.78	★★★★★
Combination #3	84.56%	86.36%	+1.80	★★★★★
Combination #4	84.44%	86.36%	+1.92	★★★★★
Combination #5	73.22%	82.48%	**+9.26**	★★★★★
Combination #6	76.02%	79.49%	+3.47	★★★★★
Combination #7	73.10%	82.48%	**+9.38**	★★★★★
Combination #8	76.02%	79.49%	+3.47	★★★★★
Combination #9	66.43%	76.05%	**+9.62**	★★★★★
Combination #10	66.43%	76.05%	**+9.62**	★★★★★
Well-Child Visits in the First 15 Months of Life				
0 Visits[€]	0.00%	0.12%	+0.12[€]	★★★★★
6 or More Visits	93.84%	93.31%	-0.53	★★★★★

[€] A lower rate indicates better performance for this measure. A positive value in the Percentage Point Change column denotes a decline in performance. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

WOMEN'S HEALTH MEASURES

Although all indicators for *Chlamydia Screening* reported rate declines, they were not statistically significant (see Table 3-24). All rates under Women's Health ranked above the national 75th percentile, with three above the 90th percentile. This finding also demonstrated that Kaiser exceeded the MQD Quality Strategy targets for all Women's Health measures.

Table 3-24—Kaiser's HEDIS Results for QUEST Measures Under Women's Health

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Chlamydia Screening in Women				
16–20 Years	68.66%	66.26%	-2.40	★★★★
21–24 Years	77.49%	74.07%	-3.42	★★★★★
Total	72.93%	69.91%	-3.02	★★★★★
Breast Cancer Screening				
Breast Cancer Screening	--	83.08%	--	★★★★★

CARE FOR CHRONIC CONDITIONS

Kaiser showed performance decline in six and improvement in four of the 11 rates (see Table 3-25). One rate (*Comprehensive Diabetes Care—Eye Exam*) did not report any rate change. One rate (*Blood Pressure Control <140/90*) reported a significant decline in performance, and one rate (*LDL-C Control*) reported a significant improvement. Nine rates met the MQD Quality Strategy targets. Of these nine rates, eight were above the 90th percentile. One rate ranked below the national 50th percentile.

Table 3-25—Kaiser's HEDIS Results for QUEST Measures Under Care for Chronic Conditions				
	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Controlling High Blood Pressure				
<140/90 mm Hg	82.97%	83.94%	+0.97	★★★★★
Comprehensive Diabetes Care				
HbA1c Testing	94.73%	94.36%	-0.37	★★★★★
HbA1c Poor Control (>9.0%)[€]	31.99%	34.39%	+2.40[€]	★★★★
HbA1c Control (<8.0%)	53.55%	51.16%	-2.39	★★★
HbA1c Control (<7.0%)	35.46%	31.72%	-3.74	★★
Eye Exam	71.90%	71.90%	0.00	★★★★★
LDL-C Screening	90.07%	93.07%	+3.00	★★★★★
LDL-C Control	56.13%	65.69%	**+9.56**	★★★★★
Nephropathy	89.96%	91.33%	+1.37	★★★★★
Blood Pressure Control (<140/80)	67.03%	62.41%	-4.62	★★★★★
Blood Pressure Control (<140/90)	87.75%	83.76%	**-3.99**	★★★★★

[€] A lower rate indicates better performance for this measure. A positive value in the Percentage Point Change column denotes a decline in performance. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

Conclusions and Recommendations

Similar to HEDIS 2013, Kaiser continued to be the top-performing QUEST health plan across all measures for HEDIS 2014. Kaiser performed at or above the MQD Quality Strategy target for 30 of 36 rates. Six rates reported statistically significant improvement and one significant decline. Overall, 30 rates ranked above the national HEDIS 2013 Medicaid 75th percentile, with 27 of those above the 90th percentile. Only one rate (*Comprehensive Diabetes Care—HbA1c Control <7.0%)* benchmarked below the 50th percentile. This indicator reported a statistically nonsignificant decline from HEDIS 2013 and continued to be an area of opportunity for improvement for Kaiser.

'Ohana's QUEST Performance

HEDIS Compliance Audit

The review team validated 'Ohana's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) 'Ohana was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-26). This demonstrated that 'Ohana had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. Due to addition of the new hybrid measures being reported by 'Ohana, a medical record convenience sample was required. Upon validation of the *Comprehensive Diabetes Care-Eye Exam (Retinal) Performed*, an error was noted, making the case noncompliant for the numerator. According to the NCQA medical record review validation (MRRV) protocol, validation of a second sample was required and subsequently passed. Primary source verification showed that all other selected measures produced by 'Ohana were prepared according to the 2014 HEDIS specifications.

'Ohana was found to be *Fully Compliant* with HEDIS reporting requirements; HSAG provided no recommendations for performance measure reporting.

Table 3-26—'Ohana: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	IS 2.0 – Enrollment Data	IS 3.0 – Provider Data	IS 4.0 – Medical Record Data	IS 5.0 – Supplemental Data	IS 6.0 – Call Center	IS 7.0 – Data Integration
Fully Compliant	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

Table 3-27 shows that 'Ohana received the audit results of *Report* for five of its selected six measures. The *Breast Cancer Screening* measure did not contain enough members (<30) to report a valid rate, therefore receiving an audit result of *NA*.

Table 3-27—'Ohana: HEDIS Compliance Audit Measure Results					
Selected Measures					
CIS	W15	CHL	CBP	CDC	BCS
Report	*Report*	*Report*	*Report*	*Report*	*NA*

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURE

All rates but one ranked below the national 25th percentile, and none met the MQD Quality Strategy targets (see Table 3-28). This finding suggests that 'Ohana should focus its improvement efforts on all these measures.

Table 3-28—'Ohana's HEDIS Results for QUEST Measures Under Children's Preventive Care

	HEDIS 2014 Rate	2014 Performance Level
Childhood Immunization Status		
DTaP	47.37%	★
IPV	73.68%	★
MMR	47.37%	★
HiB	73.68%	★
Hepatitis B	63.16%	★
VZV	50.00%	★
Pneumococcal Conjugate	47.37%	★
Hepatitis A	63.16%	★
Rotavirus	31.58%	★
Influenza	42.11%	★★
Combination #2	36.84%	★
Combination #3	36.84%	★
Combination #4	31.58%	★
Combination #5	18.42%	★
Combination #6	26.32%	★
Combination #7	15.79%	★
Combination #8	23.68%	★
Combination #9	15.79%	★
Combination #10	15.79%	★
Well-Child Visits in the First 15 Months of Life		
0 Visits[€]	15.25%	★
6 or More Visits	47.46%	★

[€] A lower rate indicates better performance for this measure. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

WOMEN'S HEALTH MEASURES

'Ohana reported valid rates on three of the four rates under Women's Health (see Table 3-29). Although 'Ohana had some members included in the *Breast Cancer Screening* measure, the number was too small (< 30) to report a valid rate. All rates were below the national 50th percentile, with two below the 25th percentile. No rates met the MQD Quality Strategy targets.

Table 3-29—'Ohana's HEDIS Results for QUEST Measures Under Women's Health

	HEDIS 2014 Rate	2014 Performance Level
Chlamydia Screening in Women		
16–20 Years	48.24%	★★
21–24 Years	51.54%	★
Total	50.23%	★
Breast Cancer Screening		
Breast Cancer Screening	NA	--

CARE FOR CHRONIC CONDITIONS

Of the 11 rates under this domain, five of 'Ohana's rates ranked above the national 50th percentile and three below the national 25th percentile (see Table 3-30). No rates met the MQD Quality Strategy targets.

Table 3-30—'Ohana's HEDIS Results for QUEST Measures Under Care for Chronic Conditions

	HEDIS 2014 Rate	2014 Performance Level
Controlling High Blood Pressure		
<140/90 mm Hg	50.76%	★★
Comprehensive Diabetes Care		
HbA1c Testing	83.58%	★★★
HbA1c Poor Control (>9.0%)[€]	56.72%	★
HbA1c Control (<8.0%)	34.70%	★
HbA1c Control (<7.0%)	25.57%	★
Eye Exam	50.75%	★★
LDL-C Screening	78.73%	★★★
LDL-C Control	29.48%	★★
Nephropathy	79.85%	★★★
Blood Pressure Control (<140/80)	41.04%	★★★
Blood Pressure Control (<140/90)	63.06%	★★★

[€] A lower rate indicates better performance for this measure. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

Conclusions and Recommendations

HEDIS 2014 was the first year 'Ohana was required to report the QUEST measure set because measurement year 2013 was 'Ohana's first full year of operation as a QUEST health plan. Therefore, year-to-year trending and comparison could not be performed. 'Ohana reported valid rates for 35 of the 36 measures/indicators. Of these 35 rates, 25 were below the national HEDIS 2013 Medicaid 25th percentile, and five were above the national 50th percentile. Nonetheless, no rates met the MQD Quality Strategy targets. There is much room for 'Ohana to improve rates for all of these measures in future HEDIS reporting years.

UnitedHealthcare CP's QUEST Performance

HEDIS Compliance Audit

The review team validated UHC CP's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) UHC CP was found to be fully compliant with all applicable IS assessment standards (Table 3-31). This demonstrated that the health plan had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures.

UHC CP contracted with a new medical record vendor for HEDIS 2014. After review of the hybrid tools and corresponding instructions, reviewer qualifications, reviewer training, and vendor oversight processes, HSAG had no issues or concerns with UHC CP's medical record review processes. In addition, due to use of a new medical record vendor, a convenience sample was required and subsequently passed. Primary source verification showed that all reported measures produced by UHC CP were prepared according to the 2014 HEDIS specifications.

UHC CP was found to be fully compliant with HEDIS reporting requirements; HSAG provided no recommendations for performance measure reporting.

Table 3-31—UHC CP: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	IS 2.0 – Enrollment Data	IS 3.0 – Provider Data	IS 4.0 – Medical Record Data	IS 5.0 – Supplemental Data	IS 6.0 – Call Center	IS 7.0 – Data Integration
Fully Compliant	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

Table 3-32 shows that UHC CP received audit results of *Report* for four of its six selected measures. Both the *Childhood Immunization Status* and the *Breast Cancer Screening* measures contained too few members (<30) to report a valid rate. Therefore, these measures received an audit result of *NA*.

Table 3-32—UHC CP: HEDIS Compliance Audit Measure Results					
Selected Measures					
CIS	W15	CHL	CBP	CDC	BCS
NA	*Report*	*Report*	*Report*	*Report*	*NA*

HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE MEASURE

UHC CP had too few members (<30) to be included in calculating the *Childhood Immunization Status* measure, resulting in *NA* designations for all indicators (see Table 3-33). As for the *Well-Child Visits in the First 15 Months of Life* measure, both rates ranked below the national 25th percentile and did not meet the MQD Quality Strategy targets.

Table 3-33—UHC CP's HEDIS Results for QUEST Measures Under Children's Preventive Care		
	HEDIS 2014 Rate	2014 Performance Level
Childhood Immunization Status		
DTaP	NA	--
IPV	NA	--
MMR	NA	--
HiB	NA	--
Hepatitis B	NA	--
VZV	NA	--
Pneumococcal Conjugate	NA	--
Hepatitis A	NA	--
Rotavirus	NA	--
Influenza	NA	--
Combination #2	NA	--
Combination #3	NA	--
Combination #4	NA	--
Combination #5	NA	--
Combination #6	NA	--
Combination #7	NA	--
Combination #8	NA	--
Combination #9	NA	--
Combination #10	NA	--
Well-Child Visits in the First 15 Months of Life		
0 Visits[€]	9.84%	★
6 or More Visits	55.74%	★

[€] A lower rate indicates better performance for this measure. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

WOMEN'S HEALTH MEASURES

UHC CP had too few members (<30) to be included in calculating the *Breast Cancer Screening* measure, resulting in an *NA* designation (see Table 3-34). All rates for the *Chlamydia Screening* measure ranked below the national 50th percentile, with one indicator (*16–20 Years*) benchmarked below the 25th percentile. None of these rates met the MQD Quality Strategy targets.

Table 3-34—UHC CP's HEDIS Results for QUEST Measures Under Women's Health

	HEDIS 2014 Rate	2014 Performance Level
Chlamydia Screening in Women		
16–20 Years	38.33%	★
21–24 Years	59.15%	★★
Total	52.97%	★★
Breast Cancer Screening		
Breast Cancer Screening	NA	--

CARE FOR CHRONIC CONDITIONS

All UHC CP's rates but one (*Comprehensive Diabetes Care—Eye Exam*) in this domain ranked below the national 50th percentiles (see Table 3-35). The *Eye Exam* indicator met the MQD Quality Strategy target. Nonetheless, six rates in this domain ranked below the national 25th percentiles.

Table 3-35—UHC CP's HEDIS Results for QUEST Measures Under Care for Chronic Conditions		
	HEDIS 2014 Rate	2014 Performance Level
Controlling High Blood Pressure		
<140/90 mm Hg	43.10%	★
Comprehensive Diabetes Care		
HbA1c Testing	79.81%	★★
HbA1c Poor Control (>9.0%)[€]	62.02%	★
HbA1c Control (<8.0%)	32.69%	★
HbA1c Control (<7.0%)	20.37%	★
Eye Exam	62.98%	★★★★
LDL-C Screening	75.00%	★★
LDL-C Control	24.04%	★
Nephropathy	78.85%	★★
Blood Pressure Control (<140/80)	31.25%	★★
Blood Pressure Control (<140/90)	49.52%	★

[€] A lower rate indicates better performance for this measure. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

Conclusions and Recommendations

HEDIS 2014 was the first year UHC CP was required to report the QUEST measure set because measurement year 2013 was UHC CP's first full year of operation as a QUEST health plan. Therefore, year-to-year trending and comparison could not be performed. UHC CP reported valid rates for 16 of the measures with the other 20 having an audit result of *NA* because of small denominators. Of the 16 valid rates, nine ranked below the national HEDIS 2013 Medicaid 25th percentile. One ranked above the 75th percentile and met the MQD Quality Strategy target. UHC CP should focus on improving the measures with low rates, particularly the *Well-Child Visits in the First 15 Months of Life* measure and the HbA1c, blood pressure, and LDL-C control indicators under *Comprehensive Diabetes Care*.

'Ohana's QExA Performance

HEDIS Compliance Audit

The review team validated 'Ohana's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) 'Ohana was found to be *Fully Compliant* with all applicable IS assessment standards (Table 3-36). This demonstrated that 'Ohana had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. Due to abstraction errors noted during the 2013 MRRV process and the addition of new hybrid measures being reported by 'Ohana, a convenience sample was required. Upon validation of the *Comprehensive Diabetes Care-Eye Exam (Retinal) Performed*, an error was noted, making the case noncompliant for the numerator. According to the NCQA MRRV protocol, validation of a second sample was required and subsequently passed. Primary source verification showed that all other selected measures produced by 'Ohana were prepared according to the 2014 HEDIS specifications.

'Ohana was found to be *Fully Compliant* with HEDIS reporting requirements; HSAG provided no recommendations for performance measure reporting.

Table 3-36—'Ohana: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	IS 2.0 – Enrollment Data	IS 3.0 – Provider Data	IS 4.0 – Medical Record Data	IS 5.0 – Supplemental Data	IS 6.0 – Call Center	IS 7.0 – Data Integration
Fully Compliant	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

Table 3-37 shows that 'Ohana received the audit results of *Report* for its selected measures.

Table 3-37—'Ohana: HEDIS Compliance Audit Results for Selected Measures					
CDC	CBP	AAP	AMB	IPU	PCR
Report	*Report*	*Report*	*Report*	*Report*	*Report*

HEDIS PERFORMANCE MEASURES RESULTS

CARE FOR CHRONIC CONDITIONS

'Ohana showed performance improvement from last year for all measures (see Table 3-38). Six of the 10 rates showed statistically significant improvement. Five rates met the MQD Quality Strategy targets, one of which ranked above the 90th percentile. Nonetheless, two rates ranked below the national 50th percentile.

Table 3-38—'Ohana's HEDIS Results for QExA Measures Under Care for Chronic Conditions

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	Performance Level
Controlling High Blood Pressure				
Controlling High Blood Pressure	--	60.50%	--	★★★
Comprehensive Diabetes Care				
HbA1c Testing	84.23%	88.11%	**+3.88**	★★★★
HbA1c Poor Control (>9.0%)[€]	45.72%	39.16%	**-6.56**[€]	★★★
HbA1c Control (<8.0%)	44.74%	52.05%	**+7.31**	★★★
HbA1c Control (<7.0%)	29.68%	32.93%	+3.25	★★
Eye Exam	57.70%	63.54%	**+5.84**	★★★★
LDL-C Screening	80.07%	83.32%	+3.25	★★★★
LDL-C Control	36.06%	43.06%	**+7.00**	★★★★
Nephropathy	83.01%	86.51%	**+3.50**	★★★★★
Blood Pressure Control (<140/80)	39.61%	40.66%	+1.05	★★★
Blood Pressure Control (<140/90)	57.95%	59.74%	+1.79	★★

[€] A lower rate indicates better performance for this measure. A negative value in the Percentage Point Change column denotes an improvement in performance. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

ACCESS TO CARE MEASURES

'Ohana showed rate increases in all four *Adults' Access to Preventive/Ambulatory Health Services* (*AAP*) indicators, though the increases were not statistically significant (see Table 3-39). All rates met the MQD Quality Strategy targets, with three ranked above the national 90th percentile.

Table 3-39—'Ohana's HEDIS Results for QExA Measures Under Access to Care

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	84.22%	86.05%	+1.83	★★★★
45–64 years	90.21%	92.15%	+1.94	★★★★★
65+ years	94.49%	95.06%	+0.57	★★★★★
Total	89.72%	91.87%	+2.15	★★★★★

UTILIZATION MEASURES

Utilization measures are presented for informational purposes and reference only because performance on these measures cannot directly be associated with quality of care. Each health plan should review its reported rates and determine what affects its performance based on the population, provider practices, and health plan initiatives.

The *Ambulatory Care—ED Visits* indicator showed an increase from HEDIS 2013 and ranked below the national 25th percentile (see Table 3-40). The *Outpatient Visits* indicator showed a slight decrease from HEDIS 2013 and was above the MQD Quality Strategy target. 'Ohana's QExA outpatient visits rate was at or above the national 90th percentile.

Eight of the 12 *Inpatient Utilization* indicators demonstrated a rate increase. The rates were not compared to the national Medicaid HEDIS percentiles because they are not directly indicative of performance, but rather provide information about member utilization and health plan resources. In addition, there were no established MQD Quality Strategy targets set for the indicators.

Table 3-40—'Ohana's HEDIS Results for QExA Utilization Measures			
	HEDIS 2013 Rate	HEDIS 2014 Rate	2014 Performance Level
Ambulatory Care			
ED Visits/1,000€	70.33	76.11	★
Outpatient Visits/1,000	750.44	748.03	★★★★★
Inpatient Utilization—General Hospital/Acute Care^			
Total Inpatient Discharges/1,000	24.18	23.32	^
Total Inpatient Days/1,000	177.48	183.91	^
Total Inpatient Average Length of Stay	7.34	7.89	^
Total Medicine Discharges/1,000	16.68	16.04	^
Total Medicine Days/1,000	85.14	90.71	^
Total Medicine Average Length of Stay	5.10	5.66	^
Total Surgery Discharges/1,000	6.95	7.00	^
Total Surgery Days/1,000	91.14	92.29	^
Total Surgery Average Length of Stay	13.11	13.18	^
Total Maternity Discharges/1,000	0.79	0.43	^
Total Maternity Days/1,000	1.72	1.41	^
Total Maternity Average Length of Stay	2.19	3.24	^

€A lower rate indicates better performance for this measure. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.
^ Results are presented for informational purposes only. There were no established MQD Quality Strategy targets for this measure. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.

The HEDIS 2014 rate for the *Plan All-Cause Readmissions* measure for all ages is presented in Table 3-41. 'Ohana reported a slight performance improvement for this measure. The Medicaid measure specifications and benchmarks have not yet been released by NCQA for this HEDIS measure. Compared to the national Medicare benchmarks, 'Ohana's rate was below the national Medicare 50th percentile. Performance level, however, is displayed as information only.

Table 3-41—'Ohana's HEDIS Results for the Plan All-Cause Readmissions Measure			
	HEDIS 2013 Rate	HEDIS 2014 Rate	2014 Performance Level
Plan All-Cause Readmissions (PCR)			
PCR Total[€]	18.94%	16.20%	★★

[€] A lower rate suggests better performance.

Note: NCQA has not yet released Medicaid measure specifications and benchmarks. Performance level is derived based on comparing the HEDIS 2014 rate against the national HEDIS 2013 Medicare benchmarks. Additionally, for performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.

Conclusions and Recommendations

'Ohana QExA's overall performance on HEDIS 2014 demonstrated some improvement from HEDIS 2013. Six rates showed statistically significant improvement and none showed significant decline. Of the 18 rates with available benchmarks for comparison, 10 ranked above the 75th percentile, with five of those ranking above the 90th percentile. These 10 rates also met the MQD Quality Strategy targets. Four rates ranked below the national HEDIS 2013 Medicaid 50th percentile, with one of them ranking below the 25th percentile. These rates, and two additional under *Comprehensive Diabetes Care*, presented opportunities for improvement.

UnitedHealthcare Community Plan's QExA Performance

HEDIS Compliance Audit

The review team validated UHC CP's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) UHC CP was found to be fully compliant with all applicable IS assessment standards (Table 3-42). This demonstrated that the health plan had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures.

UHC CP contracted a new medical records vendor for HEDIS 2014. After review of the hybrid tools and corresponding instructions, reviewer qualifications, reviewer training, and vendor oversight processes, HSAG had no issues or concerns with UHC CP's medical records review processes. In addition, due to use of a new medical record vendor, a convenience sample was required and subsequently passed. Primary source verification showed that all reported measures produced by UHC CP were prepared according to the 2014 HEDIS specifications.

UHC CP was found to be fully compliant with HEDIS reporting requirements, HSAG provided no recommendations for performance measure reporting.

Table 3-42—UHC CP: HEDIS Compliance Audit Measure Results						
Information System						
IS 1.0 – Medical Data	IS 2.0 – Enrollment Data	IS 3.0 – Provider Data	IS 4.0 – Medical Record Data	IS 5.0 – Supplemental Data	IS 6.0 – Call Center	IS 7.0 – Data Integration
Fully Compliant	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

Table 3-43 shows that UHC CP received the audit results of *Report* for its selected measures.

Table 3-43—UHC CP: HEDIS Compliance Audit Results for Selected Measures					
CDC	CBP	AAP	AMB	IPU	PCR
Report	*Report*	*Report*	*Report*	*Report*	*Report*

HEDIS PERFORMANCE MEASURES RESULTS

CARE FOR CHRONIC CONDITIONS

Of the 10 rates with results to compare to last year's performance, UHC CP reported performance improvement on eight; four had statistically significant improvement (see Table 3-44). One rate did not show any change from HEDIS 2013. One rate showed a rate decline, but it was not statistically significant. Seven rates (all under Comprehensive Diabetes Care) met the MQD Quality Strategy targets, one of which ranked above the national 90th percentile. Nonetheless, UHC CP reported two rates below the national 25th percentile.

Table 3-44—UHC CP's HEDIS Results for QExA Measures Under Care for Chronic Conditions				
	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Controlling High Blood Pressure				
Controlling High Blood Pressure	--	45.58%	--	★
Comprehensive Diabetes Care				
HbA1c Testing	83.33%	84.20%	+0.87	★★★
HbA1c Poor Control (>9.0%)[€]	41.15%	34.38%	**-6.77**[€]	★★★★
HbA1c Control (<8.0%)	52.08%	58.16%	**+6.08**	★★★★
HbA1c Control (<7.0%)	38.29%	41.08%	+2.79	★★★★
Eye Exam	60.76%	62.85%	+2.09	★★★★
LDL-C Screening	81.25%	81.25%	0.00	★★★★
LDL-C Control	42.01%	45.49%	+3.48	★★★★★
Nephropathy	86.11%	85.24%	-0.87	★★★★
Blood Pressure Control (<140/80)	32.64%	38.19%	**+5.55**	★★
Blood Pressure Control (<140/90)	43.75%	50.87%	**+7.12**	★

[€] A lower rate indicates better performance for this measure. A negative value in the Percentage Point Change column denotes an improvement in performance. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.

ACCESS TO CARE MEASURES

UHC CP showed improvement in all four indicators of the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* measures, with three reporting significant increases and meeting the national 90th percentile (see Table 3-45). All four indicators also met the MQD Quality Strategy targets.

Table 3-45—UHC CP's HEDIS Results for QExA Measure Under Access to Care

	HEDIS 2013 Rate	HEDIS 2014 Rate	Percentage Point Change	2014 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	85.51%	87.47%	+1.96	★★★★
45–64 years	91.81%	93.61%	**+1.80**	★★★★★
65+ years	95.77%	96.50%	**+0.73**	★★★★★
Total	92.80%	94.07%	**+1.27**	★★★★★

UTILIZATION MEASURES

Utilization measures are presented for informational purposes and reference only, because performance on these measures cannot directly be associated with quality of care. Each health plan should review its reported rates and determine what affects its performance based on the population, provider practices, and health plan initiatives.

Both the *ED Visits* and *Outpatient Visits* showed an increase in rate from last year (see Table 3-46). Although an increase in *ED Visits* suggests a decline in performance, UHC CP's rate still met the MQD Quality Strategy target. As for the Outpatient Visits, UHC CP ranked above the national 90th percentile and met the MQD Quality Strategy target.

Seven of 12 *Inpatient Utilization* indicators showed a decline in rates for HEDIS 2014. The rates were not compared to the national Medicaid HEDIS percentiles, because they are not directly indicative of performance, but rather provide information about member utilization and health plan resources. In addition, there were no established MQD Quality Strategy targets set for the indicators.

Table 3-46—UHC CP's HEDIS Results for QExA Utilization Measures			
	HEDIS 2013 Rate	HEDIS 2014 Rate	2014 Performance Level
Ambulatory Care			
ED Visits/1,000€	57.64	63.70	★★★
Outpatient Visits/1,000	776.94	798.97	★★★★★
Inpatient Utilization—General Hospital/Acute Care^			
Total Inpatient Discharges/1,000	20.34	19.18	^
Total Inpatient Days/1,000	164.87	183.98	^
Total Inpatient Average Length of Stay	8.11	9.59	^
Total Medicine Discharges/1,000	16.08	15.00	^
Total Medicine Days/1,000	115.82	137.52	^
Total Medicine Average Length of Stay	7.20	9.17	^
Total Surgery Discharges/1,000	4.05	4.05	^
Total Surgery Days/1,000	48.02	46.11	^
Total Surgery Average Length of Stay	11.86	11.37	^
Total Maternity Discharges/1,000	0.41	0.25	^
Total Maternity Days/1,000	2.00	0.68	^
Total Maternity Average Length of Stay	4.90	2.74	^

€ A lower rate indicates better performance for this measure. For performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance. This value also serves as the MQD Quality Strategy target.
^ Results are presented for informational purposes only. There were no established MQD Quality Strategy targets for this measure. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.

The HEDIS 2014 rate for the *Plan All-Cause Readmissions* measure for all ages is presented in Table 3-47. The HEDIS 2014 rate showed a slight decline (hence an improvement in performance) from last year. The Medicaid measure specifications and benchmarks have not yet been released by NCQA for this HEDIS measure. Compared to the national Medicare benchmarks, the HEDIS 2014 rate ranked at or above the national 50th percentile but below the 75th percentile. Performance level, nonetheless, is displayed as information only.

Table 3-47—UHC CP's QExA HEDIS Results for the Plan All-Cause Readmissions Measure			
	HEDIS 2013 Rate	HEDIS 2014 Rate	2014 Performance Level
Plan All-Cause Readmissions (PCR)			
PCR Total[€]	13.59%+	13.56%	★★★

[€] A lower rate suggests better performance.

Note: NCQA has not yet released Medicaid measure specifications and benchmarks. Performance level is derived based on comparing the HEDIS 2014 rate against the national HEDIS 2013 Medicare benchmarks. Additionally, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied to these measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.

+ HEDIS 2013 Rates were reported in last year's technical report as separate values for Ages 18-64 (15.63%) and Ages 65+ (12.10%). A total rate was displayed here based on submitted rate file.

Conclusions and Recommendations

UHC CP QExA's overall performance saw some improvement for HEDIS 2014. Seven rates reported statistically significant improvement and none reported significant decline. Twelve rates met the MQD Quality Strategy targets. Of the 18 rates with available benchmarks for comparison, 12 ranked above the national 75th percentile, with five of those ranking above the 90th percentile. Three rates ranked below the national 50th percentile, two of which were below the national 25th percentile. These three rates, all related to blood pressure control, presented opportunities for improvement for UHC CP.

'Ohana CCS Program's Performance

READINESS REVIEW RESULTS

In March of 2013, 'Ohana CCS began providing behavioral health services to QExA-enrolled members deemed as having a serious mental illness. For HEDIS 2014, the MQD required 'Ohana CCS to undergo a readiness review and performance measure validation (PMV) and report eight HEDIS measures and two non-HEDIS measures. HSAG identified no major issues associated with 'Ohana's processes in capturing its claims/encounters for the CCS population.

UHC CP QExA was required to provide 'Ohana CCS with encounter data for its CCS-enrolled members who obtained their physical health care and services via the UHC CP QExA network. This arrangement appeared to be cooperative, and 'Ohana CCS received the first data set in March 2014. This allowed time to use the data for calculation of the CCS behavioral health measures that required information about physical health diagnoses and services. For future reporting, UHC CP QExA will provide the data to 'Ohana CCS more regularly.

HEDIS AND NON-HEDIS PERFORMANCE MEASURES RESULTS

HEDIS MEASURES

Three of the 13 'Ohana CCS HEDIS measures had too few members (< 30) for calculating the HEDIS 2014 rates and therefore received NA audit designations. Of the 10 reportable rates, three ranked above the national 90th percentile (see Table 3-48).

Table 3-48—'Ohana's CCS HEDIS Results

	HEDIS 2014 Rate	Performance Level
Follow-up After Hospitalization for Mental Illness (7 Days)	35.56%	★★
Follow-up After Hospitalization for Mental Illness (30 Days)	62.22%	★★
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	--
Diabetes Screening for People with Schizophrenia and Bipolar Disorder	NA	--
Diabetes Monitoring for People with Diabetes and Schizophrenia	66.92%	★★
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	--
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation (Ages 18 and above)	38.66%	★★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement (Ages 18 and above)	13.45%	★★★
Mental Health Utilization—Total (Any Services)	83.48%	★★★★★
Mental Health Utilization--Total (Inpatient Services)	7.08%	★★★★★
Mental Health Utilization—Total (Intensive Outpatient Services)	0.90%	★★★★
Mental Health Utilization—Total (Ambulatory/ED Visits)	81.98%	★★★★★
Plan All-Cause Readmissions—Total[€]	16.41%	★★

[€] A lower rate suggests better performance. The MQD required this measure to be reported applying the Medicare weighting tables. NCQA has not yet released Medicaid measure specifications and benchmarks; therefore, performance level is derived based on comparing the HEDIS 2014 rate against the national HEDIS 2013 Medicare benchmarks. Additionally, for performance level evaluation, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.

The *Plan All-Cause Readmissions (PCR)* measure is a HEDIS measure currently approved for commercial and Medicare use, but not Medicaid. The Medicaid PCR measure specifications and benchmarks have not yet been released by NCQA. For purposes of this report, the CCS rate for PCR was compared to the national Medicare percentile and is only displayed for information. Based on the Medicare percentiles, the 2014 rate ranked at or above the national 25th percentile, but below the 50th percentile.

NON-HEDIS MEASURES

Of the three non-HEDIS measures reported for 2014, 'Ohana had too few members (<30) to calculate the two rates under *Behavioral Health Assessment and Follow-Up* (see Table 3-49). These are not HEDIS measures; therefore, national benchmarks were not available for evaluating 'Ohana's performance. Additionally, MQD Quality Strategy targets were not available for comparison.

Table 3-49—'Ohana's CCS non-HEDIS Results

	2014 Rate	Performance Level
Follow-Up With Assigned PCP After Hospitalization for Mental Illness	9.49%	--
Behavioral Health Assessment and Follow-Up (30 Days)	NA	--
Behavioral Health Assessment and Follow-Up (60 Days)	NA	--

Conclusions and Recommendations

For HEDIS 2014, 'Ohana CCS underwent a readiness review by HSAG, who also conducted performance measure validation on 10 CCS measures (a total of 16 rates). 'Ohana was able to report valid rates for 11 of the 16 rates, with five rates receiving an audit result of *NA* due to small denominator. Of the 10 rates with available HEDIS benchmarks for comparison, four ranked above the national 75th percentile, with three of those ranking above the 90th percentile. Five rates ranked below the national 50th percentile. While 'Ohana should focus on improving the CCS rates that were below the national 50th percentile, its HEDIS 2014 rates will also serve as baseline performance for future reporting years.

Validation of Performance Improvement Projects

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the presentation of validation results, the study indicator results for each health plan were compared to the results from the prior measurement period in terms of whether or not improvement and/or sustained improvement were attained.

AlohaCare

HSAG reviewed two AlohaCare PIPs: *All-Cause Readmissions* and *Diabetes Care*. Table 3-50 displays the combined validation results for the two AlohaCare PIPs evaluated during 2014. This table illustrates the plan's overall application of the PIP process and the degree to which it achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-50 show the percentage of applicable evaluation elements that received a *Met* score for each study stage and an overall score across all three stages.

Table 3-50—Performance Improvement Project Validation Results *for* AlohaCare (N=2 PIPs)

Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–VI	**100% (28/28)**
Implementation	Activities VII–VIII	**100% (23/23)**
Outcomes*	Activities IX–X	**25% (2/8)**
Overall Percentage of Applicable Elements Scored *Met*		**90% (53/59)**

*The PIPs only progressed to Activity IX for the 2014 validation.

Overall, 90 percent of the evaluation elements across the two PIPs received a score of *Met*. AlohaCare's strong performance in the Design and Implementation stages indicated that each PIP was designed and implemented appropriately to measure outcomes and improvement. For the Outcomes stage, AlohaCare had an increase in the rate of readmissions and only two of four study indicators in the *Diabetes Care* PIP demonstrated improvement. However, the improvement was not statistically significant.

Results

ALL-CAUSE READMISSIONS

Table 3-51 displays outcome data for AlohaCare's *All-Cause Readmissions* PIP. The health plan reported first remeasurement results in 2014.

Table 3-51—Performance Improvement Project Outcomes *for All-Cause Readmissions* for AlohaCare

PIP Study Indicator	Baseline Period (1/1/12–12/31/12)	Remeasurement 1 (1/1/13–12/31/13)	Sustained Improvement^
Percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 and older. ∞	10.4%	11.0%	NA

∞ The PIP indicator is an inverse indicator, wherein a decrease in the rate represents improved outcomes.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

For the *All-Cause Readmissions* PIP, AlohaCare reported a baseline rate of 10.4 percent. The *All-Cause Readmissions* PIP rate is an inverse rate wherein a decrease in the rate represents improved outcomes. AlohaCare documented a Remeasurement 1 goal of a 5 percent decrease. The first remeasurement result was 11.0 percent. This was an increase, which represents a decline in performance; however, this decline in performance was not statistically significant.

For the *All-Cause Readmissions* PIP, AlohaCare identified barriers for the first remeasurement including:

- Inability to reach members due to out-of-date contact information.
- Lack of detailed analysis to identify focus areas and priorities.
- Lack of coordination with the provider completing the transition of care pilot program.

Interventions to address barriers included:

- Face-to-face interaction between member and care coordinator prior to discharge.
- Following up with the pilot program team and scheduling quarterly meetings.
- Expanding transition of care program.

AlohaCare determined that the timing of intervention implementation in 2013 was a factor in not achieving a decrease in the readmission rate. AlohaCare documented that it plans to conduct further

analyses by provider, facility, age, and diagnosis to better understand why improvement was not achieved for the first remeasurement.

DIABETES CARE

Table 3-52 displays outcome data for AlohaCare's *Diabetes Care* PIP. The plan reported first remeasurement data in 2014.

Table 3-52—Performance Improvement Project Outcomes *for Diabetes Care* *for* AlohaCare

PIP Study Indicator	Baseline (1/1/12–12/31/12)	Remeasurement 1 (1/1/13–12/31/13)	Sustained Improvement^
1. The percentage of members with diabetes (type 1 and type 2) who had a retinal eye exam performed.	55.7%	51.1%	NA
2. The percentage of members with diabetes (type 1 and type 2) who had a blood pressure reading with the most recent reading being <140/90mmHg.	55.7%	51.2%	NA
3. The percentage of members with diabetes (type 1 and type 2) who had an HbA1c test with the most recent results being <8%.	29.4%	31.3%	NA
4. The percentage of members with diabetes (type 1 and type 2) who had an LDL-C test with the most recent results being <100mg/dL.	25.9%	26.7%	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

For the *Diabetes Care* PIP, the health plan set a goal for each study indicator: The Study Indicator 1 goal was the HEDIS 75th percentile. Study Indicators 2, 3, and 4's goals were the HEDIS 50th percentile. Study Indicators 1 and 2 had non-statistically significant declines for the first remeasurement. Study Indicators 3 and 4 had non-statistically significant increases for the first remeasurement. The goals were not reached for any study indicators.

For the *Diabetes Care* PIP, AlohaCare completed a fishbone diagram to identify barriers. The barriers included:

- Member lack of understanding of diabetes and required screenings.
- Lack of diabetes education programming and collaboration with community partners.
- Provider lack of knowledge of members' gaps in care.

AlohaCare completed member outreach interventions and reported new interventions in this year's submission including:

- Development of educational materials for use at community events.
- Formation of a multidisciplinary team to review provider reports.
- Provider education.
- Expansion of provider portal use to identify gaps in care and improve disease management collaboration.

AlohaCare documented that it has not yet fully evaluated the impact of the interventions. The health plan documented that it planned to brainstorm and discuss attainable goals for this project.

Conclusions and Recommendations

The performance on these PIPs suggests a thorough application of the PIP Design stage (Activities I through VI) and Implementation stage (Activities VII and VIII). The health plan provided the necessary documentation for both PIPs, signifying a strength for AlohaCare. The health plan documented a solid study design, including appropriate data collection activities essential to producing methodologically sound results. The Outcomes stage represented an area for improvement, as not all study indicators demonstrated improvement.

HSAG recommends the following:

- AlohaCare should investigate the reasons for a decline in performance and, based on the findings, implement strategies to improve performance. The health plan should regularly evaluate interventions to ensure that they are having the desired effects. If the health plan's evaluation of the interventions and/or review of the data indicate that the interventions are not having the desired effects, the health plan should revisit its causal/barrier analysis process; verify that or if the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

HMSA

HSAG reviewed two PIPs for HMSA: *All-Cause Readmissions* and *Diabetes Care*. This table illustrates the health plan's overall application of the PIP process and the degree to which it achieved success in implementing the PIPs. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-53 show the percentage of applicable evaluation elements that received a *Met* score for each study stage and an overall score across all three stages.

Table 3-53—Performance Improvement Project Validation Results *for* HMSA (N=2 PIPs)		
Stage	**Activities**	**Percentage of Applicable Elements Scored *Met***
Design	Activities I–VI	**100% (28/28)**
Implementation	Activities VII–VIII	**100% (24/24)**
Outcomes*	Activities IX–X	**63% (5/8)**
Overall Percentage of Applicable Elements Scored *Met*		**95% (57/60)**
* The PIPs only progressed to Activity IX for the 2014 validation.		

Overall, 95 percent of the evaluation elements across the two PIPs received a score of *Met*. HMSA's strong performance in the Design and Implementation stages indicated that each PIP was designed and implemented appropriately to measure outcomes and improvement. For the Outcomes stage, HMSA demonstrated statistically significant improvement in the *All Cause Readmissions* PIP; however, the *Diabetes Care* PIP only had improvement in one of three study indicators, and the improvement was not statistically significant.

Results

ALL-CAUSE READMISSIONS

Table 3-54 displays outcome data for HMSA's *All-Cause Readmissions* PIP. The plan submitted first remeasurement data in 2014.

Table 3-54—Performance Improvement Project Outcomes *for All-Cause Readmissions* *for* HMSA			
PIP Study Indicator	**Baseline (1/1/12–12/31/12)**	**Remeasurement 1 (1/1/13–12/31/13)**	**Sustained Improvement^**
The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 and older.∞	13.5%	10.0%↑*	NA

∞ The study indicator is an inverse indicator; therefore, a decline in the rate represents an improvement in the outcomes.
^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.
NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.
↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

For the *All-Cause Readmissions* PIP, HMSA reported a baseline rate of 13.5 percent. The *All-Cause Readmissions* PIP rate is an inverse rate wherein a decrease in the rate represents improved outcomes.

HMSA documented a Remeasurement 1 goal of 11 percent. The first remeasurement result was 10 percent. The improvement was statistically significant and the health plan surpassed its goal.

For the *All-Cause Readmissions* PIP, HMSA identified challenges associated with decreasing the readmission rate including:

- Underperforming facilities.
- Members with significant comorbidities.
- Males having higher readmission rates.
- Mental illness and substance abuse issues.
- Diabetes.

Interventions included:

- Hospital pay-for-performance program that includes a discharge planning measure.
- Working with Premier, Inc., a company with expertise in case management functions including readmission reduction.
- Partnering with Beacon Health Strategies for behavioral and medical complex case management.
- Continuing to focus on member and provider interaction for diabetic members.
- Making data available to providers.

DIABETES CARE

Table 3-55 displays outcome data for HMSA's *Diabetes Care* PIP. The plan submitted first remeasurement data in 2014.

Table 3-55—Performance Improvement Project Outcomes *for* ***Diabetes Care*** *for* HMSA			
PIP Study Indicator	**Baseline (1/1/12–12/31/12)**	**Remeasurement 1 (1/1/13–12/31/13)**	**Sustained Improvement^**
1. The percentage of members with diabetes (type 1 or type 2) who had a Hemoglobin A1c (HbA1c) test with the most recent results being <8%.	40.7%	42.2%	NA
2. The percentage of members with diabetes (type 1 or type 2) who had an LDL-C test with the most recent results being <100mg/dL.	34.5%	30.9%	NA
3. The percentage of members with diabetes (type 1 or type 2) who had a blood pressure reading with the most recent reading being <140/90mmHg.	55.1%	41.5%↓*	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

For the *Diabetes Care* PIP, Study Indicator 1, HMSA documented a Remeasurement 1 goal of 54.8 percent; and for Study Indicator 2, HMSA documented a Remeasurement 1 goal of 41.4 percent. For Study Indicator 3, HMSA documented a Remeasurement 1 goal of 68.3 percent. For Remeasurement 1, Study Indicator 1 demonstrated improvement that was not statistically significant. Study Indicators 2 and 3 demonstrated declines. No study indicator results reached the first remeasurement goals.

For the *Diabetes Care* PIP, HMSA identified three key issues in this year's submission:

- Connection between patient and doctor.
- Member adherence to treatment.
- Interventions needing to reach a broader population.

HMSA's interventions included a program focused on changing behaviors for high-risk members, disease management program, and using Patient-Centered Medical Homes (PCMHs). HMSA continued member outreach including educational mailings, engaging diabetes educators, and providing workshops in the community. In addition, HMSA offers a Pay-for-Quality program, shares data with providers, and will add medication adherence as a new pay-for-quality measure. Members receive outreach when medications are not refilled or picked up. HMSA has developed internal metrics to track changes in medication adherence.

Conclusions and Recommendations

The performance on these PIPs suggests a thorough application of the PIP Design stage and the development and implementation of appropriate interventions. The sound study design of the PIPs and the implementation of appropriate improvement strategies created the foundation for the health plan to progress to subsequent PIP stages—e.g., accurately assessing study outcomes. HMSA's PIP documentation provided evidence that the health plan appropriately conducted the data collection activities of the Design stage. These activities ensured that the PIPs were properly designed to collect the necessary data to produce accurate study indicator rates. The Outcomes stage represented an area for improvement as not all study indicators demonstrated improvement.

HSAG recommends the following:

- HMSA should investigate the reasons for a decline in performance and, based on the findings, implement strategies to improve performance. The health plan should regularly evaluate interventions to ensure that they are having the desired effects. If the health plan's evaluation of the interventions and/or review of the data indicate that the interventions are not having the desired effects, the health plan should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.
- The health plan received a *Point of Clarification* recommendation to recalculate the study indicator rates reported in Activity VII of the *Diabetes Care* PIP using 547 as the denominator.

Kaiser

HSAG reviewed two Kaiser PIPs: *All-Cause Readmissions* and *Diabetes Care*. Table 3-56 displays the combined validation results for the two Kaiser PIPs evaluated during 2014. This table illustrates the health plan's overall application of the PIP process and the degree to which it achieved success in implementing the PIPs. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-56 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-56—Performance Improvement Project Validation Results *for* Kaiser (N=2 PIPs)

Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–VI	**100% (20/20)**
Implementation	Activities VII–VIII	**100% (23/23)**
Outcomes*	Activities IX–X	**63% (5/8)**
Overall Percentage of Applicable Elements Scored *Met*		**94% (48/51)**

* The PIPs only progressed to Activity IX for the 2014 validation.

Overall, 94 percent of the evaluation elements across the two PIPs received a score of *Met*. Kaiser's strong performance in the Design and Implementation phases indicated that each PIP was designed and implemented appropriately to measure outcomes and improvement. For the Outcomes stage, Kaiser only had improvement in the *Diabetes Care* PIP.

Results

ALL-CAUSE READMISSIONS

Table 3-57 displays outcome data for Kaiser's *All-Cause Readmissions* PIP. The health plan submitted first remeasurement data in 2014.

Table 3-57—Performance Improvement Project Outcomes *for* ***All-Cause Readmissions*** *for* Kaiser			
PIP Study Indicator	**Baseline (1/1/12–12/31/12)**	**Remeasurement 1 (1/1/13–12/31/13)**	**Sustained Improvement^**
The percentage of acute inpatient stays during the measurement year that was followed by an acute readmission for any diagnosis within 30 days, for members 18 and older. ∞	10.1%	10.9%	NA

∞ The PIP indicator is an inverse indicator, wherein a decrease in the rate represents improved outcomes.

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

For the *All-Cause Readmissions* PIP, the rate is an inverse rate, wherein a decrease in the rate represents improved outcomes. Kaiser documented a Remeasurement 1 goal of 9.5 percent. The first remeasurement result was 10.9 percent, which was a non-statistically significant decline in performance. The first remeasurement goal was not achieved.

For the *All Cause Readmissions* PIP, a continuing barrier was inconsistent follow-up for patients post-discharge. To address this barrier, Kaiser continued an intervention to standardize the discharge follow-up call procedure to ensure that members receive a telephone call (within two business days post-discharge) from a clinic nurse using a standardized call template. Nurses making the calls received training about the resources available for patients. The resources included:

- Medication reconciliation.
- Home health assessment.
- Collaboration with care coordinators who worked with members in the hospital.

Ward clerks were also given access to clinic schedules and trained to schedule post-discharge follow-up with primary care providers.

Kaiser tracked post-discharge telephone calls for adult members within two business days of discharge. The baseline result was 29 percent as of December 2012. The rate decreased to 25 percent in December 2013. The health plan reported that it did not track the data throughout the year, and a revised intervention is now tracking these rates monthly by clinic.

DIABETES CARE

Table 3-58 displays outcome data for Kaiser's *Diabetes Care* PIP. The health plan submitted first remeasurement data in 2014.

Table 3-58—Performance Improvement Project Outcomes *for* ***Diabetes Care*** *for* Kaiser			
PIP Study Indicator	**Baseline (1/1/12–12/31/12)**	**Remeasurement 1 (1/1/13–12/31/13)**	**Sustained Improvement^**
The percentage of Medicaid members 18–75 years old with diabetes (type 1 and 2) who had LDL cholesterol (LDL-C) control <100mg/dL.	56.1%	65.7%↑*	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

For the *Diabetes Care* PIP, Kaiser documented a Remeasurement 1 goal of 61 percent. The first remeasurement result was 65.7 percent, a statistically significant increase. The first remeasurement result exceeded the health plan's goal.

For the *Diabetes Care* PIP, Kaiser documented continuing barriers of:

- Primary care providers not titrating medications.
- Medication adherence by members.
- Members not specifically targeted for Patient Support Services (PSS).

Kaiser reported that the main intervention in 2013 was to increase the referral of diabetic members to PSS. Members in the program are referred to primary care doctors when their LDL levels are not at the goal. Members in the program receive reminders for screenings and prescription refills. In addition, members' medications are titrated (based on evidence-based standardized protocols) by clinical pharmacists, registered nurses, or nurse practitioners. This program also tracks medication refills for members.

Kaiser evaluated how many members were referred to PSS. The baseline referral rate prior to January 2013 was 40 percent. By December 2013, the referral rate had increased to 54 percent. Due to the comprehensive services offered by PSS, Kaiser expects a positive effect on other diabetic screening and control measures.

Conclusions and Recommendations

The two PIPs submitted by Kaiser received *Met* scores for all applicable evaluation elements of the Design and Implementation stages, representing areas of strength for Kaiser. The sound study design of the PIPs created the foundation for Kaiser to progress to subsequent PIP stages—i.e., implementing additional improvement strategies and accurately assessing study outcomes. The Outcomes stage represented an area for improvement in the *All-Cause Readmissions* PIP, as the study indicator did not demonstrate improvement.

HSAG recommends the following:

- Kaiser should investigate the reasons for a decline in performance and, based on the findings, implement strategies to improve performance. The health plan should regularly evaluate interventions to ensure that they are having the desired effects. If the health plan's evaluation of the interventions and/or review of the data indicate that the interventions are not having the desired effects, the health plan should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.
- The health plan received a *Point of Clarification* recommendation to document the baseline rate in the *All-Cause Readmissions* PIP as 10.1 percent.

'Ohana QUEST

HSAG reviewed two 'Ohana QUEST PIPs: *All-Cause Readmissions* and *Diabetes Care.* Table 3-59 displays the combined validation results for the two 'Ohana QUEST PIPs evaluated during 2014. This table illustrates the health plan's overall application of the PIP process and the degree to which it achieved success in implementing the PIPs. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-59 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-59—Performance Improvement Project Validation Results *for* 'Ohana QUEST (N=2 PIPs)

Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–VI	**100% (28/28)**
Implementation	Activities VII–VIII	**100% (13/13)**
Outcomes*	Activities IX–X	***Not Assessed***
Overall Percentage of Applicable Elements Scored *Met*		**100% (41/41)**

* The PIPs did not progress past Activity VIII for the 2014 validation.

Overall, 100 percent of the evaluation elements across the two PIPs received a score of *Met*. 'Ohana demonstrated strong performance in the Design and Implementation stages, indicating that each PIP was designed and implemented appropriately to measure outcomes and improvement.

Results

ALL-CAUSE READMISSIONS

Table 3-60 displays outcome data for 'Ohana's *All-Cause Readmissions* PIP. In 2014, 'Ohana QUEST completed Activities I through VIII. The health plan reported baseline data from calendar year 2013.

Table 3-60—Performance Improvement Project Outcomes *for All-Cause Readmissions* *for* 'Ohana *QUEST*

PIP Study Indicator	Baseline (1/1/13–12/31/13)	Sustained Improvement^
The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 and older. ∞	18.8%	NA

∞ The PIP indicator is an inverse indicator, wherein a decrease in the rate represents improved outcomes.

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

The *All-Cause Readmissions* PIP progressed to reporting baseline results. For the study indicator, a decrease represents improvement; therefore, the health plan set a goal of 17 percent.

For the *All-Cause Readmissions* PIP, 'Ohana identified member, provider, and system barriers. To address the barriers, the health plan implemented interventions that included:

- Case management program.
- Service coordinator outreach.
- Hospitalization Utilization Readmission Review Team.
- Assisting with discharge planning for high-risk members.
- Member outreach.

The health plan identified an additional barrier of not being able to reach members and has developed an action plan to research updated telephone numbers for members.

DIABETES CARE

Table 3-61 displays outcome data for 'Ohana QUEST's *Diabetes Care* PIP. In 2014, 'Ohana completed Activities I through VIII. The health plan reported baseline data from calendar year 2013.

Table 3-61—PIP Validation Overall Score *for* ***Diabetes Care*** *for* **'Ohana QUEST**		
PIP Study Indicator	**Baseline (1/1/13–12/31/13)**	**Sustained Improvement^**
1. The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) test.	83.6%	NA
2. The percentage of members 18–75 year of age with diabetes (type 1 and type 2) who had an LDL-C screening.	78.7%	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

For the *Diabetes Care* PIP, the health plan set goals for Study Indicators 1 and 2 as 87 percent and 80 percent, respectively.

'Ohana documented that its quality workgroups meet regularly to discuss barriers, interventions, and data mining. The health plan prioritized barriers into four main issues for the *Diabetes Care* PIP; getting the member to the doctor, getting the doctor to do the right service, getting the encounter report, and data management. In 2013, the health plan implemented interventions to address the barriers that included:

- Disease management program.
- Modified script for disease management outreach due to members declining to enroll.
- Member newsletters.
- Identifying members with care gaps using CareConnect.
- Interactive online provider portal for identifying member care gaps.
- Training care managers on HEDIS care gaps.
- Centralized Telephonic Outreach (CTO) calls to members with care gaps.
- Provider visits with distribution of HEDIS toolkits.

Conclusions and Recommendations

'Ohana's PIPs received *Met* scores for 100 percent of the evaluation elements in the Design and Implementation stages (Activities I through VIII), areas of strength for 'Ohana. The solid foundation of the PIPs allows for the health plan to progress to the next stage of the PIP process. There were no recommendations. Both PIPs received a 100 percent—*Met* validation status.

‘Ohana QExA

HSAG reviewed two ‘Ohana QExA PIPs: *Assessing the Documentation of Body Mass Index (BMI)* and *Diabetes Care*. Table 3-62 displays the combined validation results for the two ‘Ohana QExA PIPs evaluated during 2014. This table illustrates the health plan’s overall application of the PIP process and the degree to which it achieved success in implementing the PIPs. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-62 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-62—Performance Improvement Project Validation Results *for* ‘Ohana QExA (N=2 PIPs)

Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–VI	**100% (35/35)**
Implementation	Activities VII–VIII	**100% (26/26)**
Outcomes	Activities IX–X	**100% (10/10)**
Overall Percentage of Applicable Elements Scored *Met*		**100% (71/71)**

‘Ohana’s strong performance indicates that the PIPs were appropriately designed and implemented—the interventions were designed to change behavior at a system-, provider-, or member-level and the data were appropriately analyzed and interpreted. Both PIPs demonstrated success in the Outcomes stage by achieving statistically significant over baseline for all study indicators and sustained improvement for the assessed study indicators.

Results

ASSESSING THE DOCUMENTATION OF BODY MASS INDEX (BMI)

Table 3-63 displays outcome data for ‘Ohana QExA’s *Assessing the Documentation of Body Mass Index (BMI)* PIP. In 2014, ‘Ohana reported second remeasurement period results.

Table 3-63—Performance Improvement Project Outcomes *for* ***Assessing the Documentation of Body Mass Index (BMI)*** *for* **'Ohana QExA**				
PIP Study Indicator	**Baseline (1/1/11–12/31/11)**	**Remeasurement 1 (1/1/12–12/31/12)**	**Remeasurement 2 (1/1/13–12/31/13)**	**Sustained Improvement^**
1. Percentage of members 3–17 years of age who had a documented BMI.	48.2%	33.6%↓*	56.7%↑*	NA
2. Percentage of members 3–17 years of age who had documentation of nutritional counseling.	32.4%	37.5%	49.1%↑*	NA
3. Percentage of members 18–74 years of age who had documentation of BMI.	54.5%	69.3%↑*	72.3%	Yes

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

The *Assessing the Documentation of Body Mass Index (BMI)* PIP study indicator rates all demonstrated improvement for the second remeasurement. Study Indicators 1 and 2 demonstrated statistically significant improvement, and Study Indicator 3 demonstrated sustained improvement in this year's submission; however, the rates were still below 'Ohana's reported study indicator goals. The Study Indicator 1 goal was 70 percent, the Study Indicator 2 goal was 68 percent, and the Study Indicator 3 goal was 79 percent.

In the *Assessing the Documentation of Body Mass Index (BMI)* PIP, 'Ohana documented that barrier analysis continued to be discussed by the quality workgroups. The barriers were prioritized into four main issues: getting the member to the doctor, getting the doctor to do the right service, getting the encounter report, and data management. Interventions included letters sent to members in their translated languages and educational visits to providers with distribution of HEDIS toolkits and care gap lists. The Centralized Telephonic Outreach (CTO) program also continued. Members with care gaps receive a call to make an appointment with a physician and transportation is arranged. The health plan evaluated the number of appointments scheduled quarterly. The initial result was 19 percent, and it subsequently increased to 45 percent.

'Ohana identified a barrier of reaching members due to not having current contact information. An action plan developed to address this barrier included searching for an updated telephone number from hospital admission records or prior authorization forms.

DIABETES CARE

Table 3-64 displays outcome data for 'Ohana QExA's *Diabetes Care* PIP. In 2014, the health plan reported data from baseline through the fourth remeasurement period.

Table 3-64—PIP Validation Overall Score for *Diabetes Care* for 'Ohana QExA

PIP Study Indicator	Baseline (2/1/09–12/31/09)	Remeasurement 1 (1/1/10–12/31/10)	Remeasurement 2 (1/1/11–12/31/11)	Remeasurement 3 (1/1/12–12/31/12)	Remeasurement 4 (1/1/13–12/31/13)	Sustained Improvement^
1. Percentage of members who received an HbA1c screening during the measurement year.	83.2%	82.1%	81.4%	84.2%	88.1%↑*	NA
2. Percentage of members who had at least one LDL-C screening during the measurement year.	79.0%	74.8%	75.9%	80.1%	83.3%	NA
3. Percentage of members who had at least one retinal eye exam during the measurement year.	43.4%	54.0%↑*	57.7%	57.7%	63.5%↑*	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

↑* Designates statistically significant improvement over the prior measurement period (p value < 0.05).

↓* Designates statistically significant decline in performance over the prior measurement period (p value < 0.05).

For the *Diabetes Care* PIP, all study indicators demonstrated statistically significant improvement over baseline for Remeasurement 4 and Study Indicator 3 demonstrated sustained improvement. Study Indicators 1 and 2 reached the goals of 87 percent and 80 percent, respectively. Study Indicator 3 was just slightly below the goal of 64 percent.

For the *Diabetes Care* PIP, 'Ohana documented the same four main barriers identified for the *BMI* PIP. An additional barrier was that members lacked knowledge of diabetes self-management. To address this barrier, the disease management program continued; however, the health plan reported challenges with increasing enrollment and keeping members enrolled. Member outreach was modified to address this challenge. In addition, service coordinators outreached members with care

gaps. Educational visits to providers continued. These visits included the distribution of HEDIS toolkits and care gap lists.

Community Case Management Agencies who managed foster home members continued to receive care gaps and ensured that members were scheduled for appointments with physicians. A new member outreach was implemented in December 2013 to address diabetic eye exam gaps. The health plan partnered with a nonprofit organization, Project Vision, which provides free diabetic retinal eye exams from a van. Staff contacted members to schedule eye appointments for an event offering 13 appointments. All 13 appointments were scheduled; however, only 11 members attended.

Another issue identified was medical records retrieval; up to 25 percent could not be retrieved during the HEDIS medical record review period. To address this issue, the health plan hired 24 temporary staff members to schedule and retrieve records. As a result, ‘Ohana reported a decrease to 7 percent of medical records not retrieved.

Conclusions and Recommendations

The ‘Ohana PIPs were developed with a solid study design essential to producing methodologically sound results. The data analysis and interpretation of the PIP results were appropriate and adhered to the statistical analysis techniques. ‘Ohana demonstrated success in the Outcomes stage for both PIPs. There are no recommendations at this time. Both PIPs received a 100 percent—*Met* validation status.

‘Ohana CCS

HSAG reviewed two ‘Ohana CCS PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*. Table 3-65 displays the combined validation results for the two ‘Ohana CCS PIPs evaluated during 2014. This table illustrates the health plan’s overall application of the PIP process and the degree to which it achieved success in implementing the PIPs. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-65 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-65—Performance Improvement Project Validation Results *for* ‘Ohana CCS (N=2 PIPs)

Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–VI	**100% (20/20)**
Implementation*	Activities VII–VIII	**100% (8/8)**
Outcomes	Activities IX–X	***Not Assessed***
Overall Percentage of Applicable Elements Scored *Met*		**100% (28/28)**

* The PIPs were only assessed through Activity VII for the 2014 validation.

Overall, 100 percent of the evaluation elements across the two PIPs received a score of *Met*. 'Ohana CCS' strong performance in the Design phase indicated that each PIP was appropriately designed to measure outcomes and improvement.

Results

Table 3-66—Performance Improvement Project Outcomes *for* ***Follow-up After Hospitalization for Mental Illness*** *for* 'Ohana CCS		
PIP Study Indicator	**Baseline (1/1/13–12/31/13)**	**Sustained Improvement^**
Study Indicator 1: The percentage of members who had a follow-up visit with a behavioral health provider within 7 days of discharge from an inpatient facility for treatment of mental illness.	35.56%	NA
Study Indicator 2: The percentage of members who had a follow-up visit with a behavioral health provider within 30 days of discharge from an inpatient facility for treatment of mental illness.	62.22%	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

'Ohana's *Follow-up After Hospitalization for Mental Illness* PIP included baseline results and set goals of 44.66 percent for Study Indicator 1 and 65.85 percent for Study Indicator 2.

Barriers and interventions were not assessed in either PIP because only baseline data were included in this year's submission.

Table 3-67—Performance Improvement Project Outcomes *for* ***Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*** *for* 'Ohana CCS		
PIP Study Indicator	**Baseline (1/1/13–12/31/13)**	**Sustained Improvement^**
Study Indicator 1: Initiation of AOD dependence treatment: the percentage of CCS members diagnosed with AOD dependence who initiated treatment through an inpatient AOD admission or an outpatient service for AOD abuse or dependence and any additional AOD services within 14 days.	38.66%	NA
Study Indicator 2: Engagement of AOD treatment: the percentage of eligible CCS members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of diagnosis during the intake period (January 1 through November 15 of the measurement year).	13.45%	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

The *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* PIP also included baseline results in this year's submission. 'Ohana set goals of 39.16 percent for Study Indicator 1 and 16.17 percent for Study Indicator 2.

Conclusions and Recommendations

The 'Ohana PIPs were developed with a solid study design essential to producing methodologically sound results. For both PIPs, 'Ohana appropriately conducted data analysis for the baseline measurement period. Both 'Ohana PIPs received a 100 percent—*Met* validation score. There were no recommendations for improvement in this year's validation.

UnitedHealthcare Community Plan QUEST

HSAG reviewed two UHC CP QUEST PIPs: *All-Cause Readmissions* and *Diabetes Care.* Table 3-68 displays the combined validation results for the two UHC CP QUEST PIPs evaluated during 2014. This table illustrates the health plan's overall application of the PIP process and the degree to which it achieved success in implementing the PIPs. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-68 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-68—Performance Improvement Project Validation Results *for* UHC CP QUEST (N=2 PIPs)

Stage	Activities	Percentage of Applicable Elements Scored *Met*
Design	Activities I–VI	**100% (21/21)**
Implementation*	Activities VII–VIII	**100% (8/8)**
Outcomes	Activities IX–X	*Not Assessed*
Overall Percentage of Applicable Elements Scored *Met*		**100% (29/29)**

* The PIPs did not progress past Activity VII for the 2014 validation.

Overall, 100 percent of the evaluation elements across the two PIPs received a score of *Met*. UHC CP's strong performance in the Design phase indicated that each PIP was appropriately designed to measure outcomes and improvement. UHC CP met the requirements for baseline data analysis in Activity VII of the Implementation stage.

Results

ALL-CAUSE READMISSIONS

Table 3-69 displays UHC CP QUEST's results for the *All-Cause Readmissions* PIP. In 2014, UHC CP completed Activities I through VII. The health plan reported baseline data from calendar year 2013.

Table 3-69—Performance Improvement Project Outcomes *for All-Cause Readmissions* *for* UHC CP QUEST

PIP Study Indicator	Baseline (1/1/13–12/31/13)	Sustained Improvement^
The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days, for members 18 and older. ∞	5.5%	NA

∞ The PIP indicator is an inverse indicator, wherein a decrease in the rate represents improved outcomes.
NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.
^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

The UHC CP *All-Cause Readmissions* PIP progressed to reporting baseline data during the review period. The baseline result was 5.5 percent. This was lower than the benchmark of 10.16 percent reported by the health plan. The PIP indicator is an inverse indicator, wherein a decrease in the rate represents improved outcomes.

UHC CP completed a fishbone diagram in the baseline year for each of the PIPs that included barriers identified in the categories of member, provider, health plan, and state. In addition, the health plan documented that it plans to complete Plan-Do-Study-Act (PDSA) cycles. UHC CP indicated that the barrier analysis would be updated after the baseline results of the PIP were finalized in June 2014. UHC CP did not progress to Activity VIII (Implement Intervention and Improvement Strategies) during the current validation period.

DIABETES CARE

Table 3-70 displays UHC CP QUEST's results for the *Diabetes Care* PIP. In 2014, UHC CP completed Activities I through VII. The health plan reported baseline data from calendar year 2013.

Table 3-70—Performance Improvement Project Outcomes *for* ***Diabetes Care*** *for* UHC CP QUEST		
PIP Study Indicator	**Baseline (1/1/13–12/31/13)**	**Sustained Improvement^**
1. The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a Hemoglobin A1c (HbA1c) test.	32.7%	NA
2. The percentage of members 18–75 year of age with diabetes (type 1 and type 2) who had an LDL-C screening.	24.0%	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

For the *Diabetes Care* PIP, the health plan set goals for Study Indicators 1 and 2 at 48.6 percent and 34.9 percent, respectively.

Conclusions and Recommendations

The *All-Cause Readmissions* and *Diabetes Care* PIPs received *Met* scores for all six activities in the Design stage and Activity VII in the Implementation stage. The strong performance of UHC CP's PIPs in Activities I through VII suggests a solid application of the PIP. The sound design of the PIPs created the foundation for UHC CP to progress to subsequent PIP stages—e.g., implementing improvement strategies.

HSAG recommends the following:

- For the *All-Cause Readmissions* PIP, the resubmission still included "Observed to Expected Ratio" in the study indicator title. The health plan should remove this as it does not apply to the methodology for this PIP.
- For the *Diabetes Care* PIP, the health plan should correct the interpretation for Study Indicator 2 to state the correct goal.

UnitedHealthcare Community Plan QExA

HSAG reviewed two UHC CP QExA PIPs: *Assessing the Documentation of Body Mass Index (BMI)* and *Diabetes Care.* Table 3-71 displays the combined validation results for the two UHC CP QExA PIPs evaluated during 2014. This table illustrates the health plan's overall application of the PIP process and the degree to which it achieved success in implementing the PIPs. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-71 show the percentage of applicable evaluation elements that received each score by study stage and an overall score across all three stages.

Table 3-71—Performance Improvement Project Validation Results *for* UHC CP QExA (N=2 PIPs)

Stage	Activities	
Design	Activities I–VI	**100% (35/35)**
Implementation	Activities VII–VIII	**100% (25/25)**
Outcomes	Activities IX–X	**78% (7/9)**
Overall Percentage of Applicable Elements Scored *Met*		**97% (67/69)**

UHC CP's strong performance in Activities I through VIII indicates that the PIPs were appropriately designed to measure outcomes and improvement, and the health plan properly implemented intervention and improvement strategies and accurately analyzed and interpreted the PIP results. In the Outcomes stage, the *Diabetes Care* PIP did not have statistically significant improvement in all study indicators, resulting in two *Not Met* scores in Activity IX. The *Assessing the Documentation of Body Mass Index (BMI)* PIP achieved sustained improvement in this year's submission.

Results

ASSESSING THE DOCUMENTATION OF BODY MASS INDEX (BMI)

UHC CP QExA progressed to the point of reporting third remeasurement data in 2014 for the *BMI* PIP. Table 3-72 displays UHC CP's results for the *BMI* PIP.

Table 3-72—Performance Improvement Project Outcomes *for* ***Assessing the Documentation of Body Mass Index (BMI)*** *for* UHC CP QExA					
PIP Study Indicator	**Baseline (1/1/10–12/31/10)**	**Remeasurement 1 (1/1/11–12/31/11)**	**Remeasurement 2 (1/1/12–12/31/12)**	**Remeasurement 3 (1/1/13–12/31/13)**	**Sustained Improvement^**
1. Percentage of eligible members 3–17 years of age who had evidence of BMI percentile documented during the measurement year.	11.68%	16.30%	25.00%↑*	38.80%↑*	Yes
2. Percentage of eligible members 18–74 years of age who had evidence of BMI percentile documented during the measurement year.	23.84%	35.42%↑*	49.77%↑*	70.60%↑*	Yes

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

The Study Indicator 1 rate for the *Assessing the Documentation of Body Mass Index (BMI)* PIP showed statistically significant improvement from 25.00 percent to 38.80 percent for Remeasurement 3. Study Indicator 2 of the *Assessing the Documentation of Body Mass Index (BMI)* PIP also had statistically significant improvement, with the rate increasing from 49.77 percent to 70.60 percent for Remeasurement 3. Sustained improvement was achieved for this PIP.

For UHC CP's *Assessing the Documentation of Body Mass Index (BMI)* PIP, the health plan identified barriers in this year's submission as: health plan resource constraints, community case management agencies' (CCMAs') knowledge deficit about HEDIS requirements, and members not visiting their primary care providers. In 2013, UHC CP continued several member, provider, and system interventions that included member and provider outreach. UHC CP documented that it primarily focused on interventions that "leveraged the high touch-point" of the plan's field service coordinators and CCMAs with members.

- The health plan conducted several trainings for both service coordinators and CCMAs to raise awareness of HEDIS requirements. The training emphasized BMI documentation.
- Both service coordinators and CCMAs were provided with HEDIS care gap reports that included member-specific information.
- Efforts were made to aid service coordinators in outreach efforts.
- The health plan hired bilingual employees to address cultural barriers.
- The health plan organized the Hawaii Health Conference held in February 2014. At this conference, clarifications regarding the study indicators were discussed and educational materials were distributed to providers.

UHC CP documented that it plans to continue these interventions.

DIABETES CARE (QEXA)

UHC CP progressed to the point of reporting third remeasurement data in 2014 for the diabetes PIP. Table 3-73 displays UHC CP's results for the *Diabetes Care* PIP.

Table 3-73—Performance Improvement Project Outcomes *for Diabetes Care* for UHC CP QExA

PIP Study Indicator	Baseline (1/1/10–12/31/10)	Remeasurement 1 (1/1/11–12/31/11)	Remeasurement 2 (1/1/12–12/31/12)	Remeasurement 3 (1/1/13–12/31/13)	Sustained Improvement^
1. Percentage of members 18–75 years of age who received at least one HbA1c screening during the measurement year.	80.90%	82.47%	83.33%	84.20%	NA
2. Percentage of members 18–75 years of age who had a dilated retinal eye exam or who had a negative retinal exam performed during the measurement year.	59.20%	61.98%	60.76%	62.85%	NA

NA Statistically significant improvement over baseline and a subsequent measurement must occur before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement for all study indicators when compared to the baseline results.

In the *Diabetes Care* PIP, both study indicators demonstrated improvement during Remeasurement 3; however, the improvement was not statistically significant. Study Indicator 1 improved from a rate of 83.33 percent in Remeasurement 2 to 84.20 percent in Remeasurement 3. The Study Indicator 2 rate improved from 60.76 percent in Remeasurement 2 to 62.85 percent in Remeasurement 3; however, statistically significant improvement over baseline has not yet been achieved for the *Diabetes Care* PIP.

During Remeasurement 3, UHC CP updated its *Diabetes Care* fishbone diagram to reflect new barriers: inadequate assistance to providers for claims concerns by contracted vendor, health plan resource constraints, inability to reach providers for medical record abstraction, and CCMA knowledge deficit about HEDIS requirements. UHC CP continued member, provider, and system interventions including member and provider outreach. The health plan reported revised and new interventions that included:

- Inclusion of study indicators in provider incentive programs.
- Increased efforts involving service coordinators in improving member compliance.
- Production of member-specific reports to address noncompliance.
- Distribution of reminder letters to members.
- Updating diabetes disease management materials.
- Improved coordination with service coordinators.
- Provider advocates assisting with and providing training about billing/coding.
- Improved customer service to members acquiring services.
- Improvement initiative for members that could not be found.

UHC CP also documented that the Accountable Care Communities program would continue to share data with high-volume providers and that there would be an addition of clinical practice consultants to focus on provider interventions and an addition of quality team members dedicated to quality performance improvement.

Conclusions and Recommendations

Both PIPs received a *Met* score for all six activities in the Design stage. UHC CP appropriately conducted the sampling, data collection, and improvement strategy activities of the Implementation stage. The health plan demonstrated sustained improvement for the *BMI* PIP. The *Diabetes Care* PIP demonstrated improvement; however, the improvement was not statistically significant over the baseline.

HSAG recommends the following:

- For the *Diabetes Care* PIP, the health plan should correct the *p* value for Study Indicator 2 from baseline to the first remeasurement.
- For the *Diabetes Care* PIP, the improvement was not statistically significant for either study indicator. UHC CP should implement strategies to improve performance. The health plan should regularly evaluate interventions to ensure that they are having the desired effects. If the health plan's evaluation of interventions and/or review of data indicates that the interventions

are not having the desired effect, the health plan should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions, as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

- For the *BMI* PIP, the health plan should ensure that all percentage point differences between measurement periods and Chi-square test results are reported accurately and consistently throughout the PIP Summary Form.
- With its successful and sustained improvement on this PIP, UHC CP may want to consider it for retirement, with approval from the MQD to do so.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey

AlohaCare

Results

Table 3-74 presents the 2012 and 2014 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response), overall 2014 member satisfaction ratings (i.e., star ratings), and trending results for each of the global ratings and four composite measures for AlohaCare.[3-2,3-3, 3-4]

Table 3-74—Adult Medicaid CAHPS Results *for* AlohaCare

Measure	2012 Rates	2014 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	53.2%	54.4%	★★
Rating of All Health Care	46.3%	45.6%	★★
Rating of Personal Doctor	62.4%	63.4%	★★★★
Rating of Specialist Seen Most Often	59.7%+	65.7%	★★★
Composite Measures			
Getting Needed Care	70.2%+	74.3%	★
Getting Care Quickly	69.4%	76.1%	★
How Well Doctors Communicate	89.6%	90.2%	★★★★
Customer Service	69.7%+	79.1%	★

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

3-2 AlohaCare's 2012 rates for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the 2012 results for all composite measures presented in this section will not match the 2012 report.

3-3 Due to changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting trending results for this measure.

3-4 Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

The overall member satisfaction ratings revealed that AlohaCare scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on two measures: *Rating of Personal Doctor* and *How Well Doctors Communicate*.
- At or between the 50th and 74th percentiles on one measure: *Rating of Specialist Seen Most Often*.
- At or between the 25th and 49th percentiles on two measures: *Rating of Health Plan* and *Rating of All Health Care.*
- Below the 25th percentile on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

A comparison of AlohaCare's 2012 scores to its corresponding 2014 scores revealed that AlohaCare did not score significantly higher or lower in 2014 than in 2012 on any measure.

Conclusions and Recommendations

Based on an evaluation of AlohaCare's results, the priority areas identified were *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in each of these areas.

GETTING NEEDED CARE

Appropriate Health Care Providers—The health plan should ensure that patients are receiving care from physicians most appropriate to treat their conditions. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care timely.

Interactive Workshops—The health plan should engage in promoting health education, health literacy, and preventive health care among its membership. The health plan can develop community-based interactive workshops and educational materials to provide information about general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.

"Max-Packing"—The health plan can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit as feasible—a process called "max-packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.

Referral Process—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, may improve communication mechanisms between PCPs and

specialists to determine which clinical conditions require a referral and allows providers access to a standardized referral form to ensure that all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

Open Access Scheduling—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.

Patient Flow Analysis—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

CUSTOMER SERVICE

Call Centers—An evaluation of current health plan call center hours and practices may be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center should be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call may assist in determining if members are receiving the help they need and identify potential areas for customer service improvement.

Creating an Effective Customer Service Training Program—The health plan should consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators might be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult

patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

Customer Service Performance Measures—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified, as needed.

HMSA

Results

Table 3-75 presents the 2012 and 2014 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response), overall 2014 member satisfaction ratings (i.e., star ratings), and trending results for each of the global ratings and four composite measures for HMSA.[3-5,3-6,3-7]

Table 3-75—Adult Medicaid CAHPS Results *for* HMSA

Measure	2012 Rates	2014 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	58.9%	55.2%	★★★
Rating of All Health Care	54.6%	46.8% ▼	★★
Rating of Personal Doctor	56.4%	60.6%	★★
Rating of Specialist Seen Most Often	60.7%	59.2%	★
Composite Measures			
Getting Needed Care	75.4%	77.7%	★
Getting Care Quickly	75.6%	77.7%	★
How Well Doctors Communicate	91.5%	88.7%	★★★
Customer Service	79.4%+	84.3%+	★+

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

▲ Indicates the 2014score is significantly higher than the 2012 score.
▼ Indicates the 2014 score is significantly lower than the 2012 score.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that HMSA scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on no measures.
- At or between the 50th and 74th percentiles on two measures: *Rating of Health Plan* and *How Well Doctors Communicate*.

[3-5] HMSA's 2012 rates for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the 2012 results for all composite measures presented in this section will not match the 2012 report.

[3-6] Due to changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting trending results for this measure.

[3-7] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

- At or between the 25th and 49th percentiles on two measures: *Rating of All Health Care* and *Rating of Personal Doctor*.
- Below the 25th percentile on four measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

A comparison of HMSA's 2012 scores to its corresponding 2014 scores revealed that HMSA scored significantly lower in 2014 than in 2012 on one measure, *Rating of All Health Care*.

Conclusions and Recommendations

Based on an evaluation of HMSA's results, the priority areas identified were *Customer Service*, *Getting Care Quickly*, *Getting Needed Care*, and *Rating of Specialist Seen Most Often*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in these areas.

CUSTOMER SERVICE

Call Centers—An evaluation of current health plan call center hours and practices may be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center should be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call may assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

Creating an Effective Customer Service Training Program—The health plan should consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators might be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

Customer Service Performance Measures—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified, as needed.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors

(e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

Open Access Scheduling—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.

Patient Flow Analysis—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

GETTING NEEDED CARE

Appropriate Health Care Providers—The health plan should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner.

Interactive Workshops—The health plan should engage in promoting health education, health literacy, and preventive health care among its membership. The health plan can develop community-based interactive workshops and educational materials to provide information about general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.

"Max-Packing"—The health plan can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit as feasible—a process called "max-packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.

Referral Process—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, may improve communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral and allows providers access

to a standardized referral form to ensure that all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plan should work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plan may create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

Telemedicine—Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

Kaiser

Results

Table 3-76 presents the 2012 and 2014 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response), overall 2014 member satisfaction ratings (i.e., star ratings), and trending results for each of the global ratings and four composite measures for Kaiser. [3-8,3-9,3-10]

Table 3-76—Adult Medicaid CAHPS Results *for* Kaiser

Measure	2012 Rates	2014 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	69.1%	67.8%	★★★★★
Rating of All Health Care	62.5%	66.5%	★★★★★
Rating of Personal Doctor	72.6%	74.0%	★★★★★
Rating of Specialist Seen Most Often	66.0%	60.5%	★
Composite Measures			
Getting Needed Care	84.5%	82.2%	★★
Getting Care Quickly	84.5%	81.1%	★★★
How Well Doctors Communicate	94.8%	94.7%	★★★★★
Customer Service	89.0%+	88.7%+	★★★+

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that Kaiser scored:

- At or above the 90th percentile on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *How Well Doctors Communicate*.
- At or between the 75th and 89th percentiles on no measures.
- At or between the 50th and 74th percentiles on two measures: *Getting Care Quickly* and *Customer Service*.
- At or between the 25th and 49th percentiles on one measure, *Getting Needed Care.*
- Below the 25th percentile on one measure, *Rating of Specialist Seen Most Often*.

[3-8] Kaiser's 2012 rates for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the 2012 results for all composite measures presented in this section will not match the 2012 report.

[3-9] Due to changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting trending results for this measure.

[3-10] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

A comparison of Kaiser's 2012 scores to its corresponding 2014 scores revealed that Kaiser did not score significantly higher or lower in 2014 than in 2012 on any measure.

Conclusions and Recommendations

Based on an evaluation of Kaiser's results, the priority areas identified were *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in these areas.

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plan should work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plan may create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

Telemedicine—Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

GETTING NEEDED CARE

Appropriate Health Care Providers—The health plan should ensure that patients are receiving care from physicians most appropriate to treat their conditions. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care timely.

Interactive Workshops—The health plan should engage in promoting health education, health literacy, and preventive health care among its membership. The health plan can develop community-based interactive workshops and educational materials to provide information

about general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.

"Max-Packing"—The health plan can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit as feasible—a process called "max-packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.

Referral Process—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, may improve communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral and allows providers access to a standardized referral form to ensure that all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

Open Access Scheduling—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.

Patient Flow Analysis—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

‘Ohana QUEST and QExA

QUEST Results

Table 3-77 presents the 2014 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) and overall 2014 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for ‘Ohana QUEST.[3-11,3-12]

Table 3-77—Adult Medicaid CAHPS Results *for* ‘Ohana QUEST

Measure	2014 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	51.4%	★
Rating of All Health Care	49.1%	★★
Rating of Personal Doctor	62.2%	★★★
Rating of Specialist Seen Most Often	63.7%	★★★
Composite Measures		
Getting Needed Care	72.4%	★
Getting Care Quickly	74.6%	★
How Well Doctors Communicate	90.2%	★★★★
Customer Service	83.4%	★

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that ‘Ohana QUEST scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on one measure, *How Well Doctors Communicate.*
- At or between the 50th and 74th percentiles on two measures: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often.*
- At or between the 25th and 49th percentiles on one measure, *Rating of All Health Care*.
- Below the 25th percentile on four measures: *Rating of Health Plan*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

[3-11] 2014 represents the first year ‘Ohana QUEST adult members were surveyed; therefore, 2012 rates are not available for the health plan.

[3-12] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

QExA Results

Table 3-78 presents the 2012 and 2014 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response), overall 2014 member satisfaction ratings (i.e., star ratings), and trending results for each of the global ratings and four composite measures for 'Ohana QExA.[3-13,3-14,3-15]

Table 3-78—Adult Medicaid CAHPS Results *for* 'Ohana QExA

Measure	2012 Rates	2014 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	49.3%	50.3%	★
Rating of All Health Care	48.5%	44.7%	★
Rating of Personal Doctor	65.5%	64.2%	★★★
Rating of Specialist Seen Most Often	59.3%	69.9% ▲	★★★★★
Composite Measures			
Getting Needed Care	74.6%	79.2%	★
Getting Care Quickly	79.0%	77.8%	★
How Well Doctors Communicate	88.6%	89.0%	★★★
Customer Service	70.3%	87.5% ▲	★★

▲ Indicates the 2014 score is significantly higher than the 2012 score.
▼ Indicates the 2014 score is significantly lower than the 2012 score.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that 'Ohana QExA scored:

- At or above the 90th percentile on one measure, *Rating of Specialist Seen Most Often*.
- At or between the 75th and 89th percentiles on no measures.
- At or between the 50th and 74th percentiles on two measures: *Rating of Personal Doctor* and *How Well Doctors Communicate.*
- At or between the 25th and 49th percentiles on one measure, *Customer Service*.
- Below the 25th percentile on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, and *Getting Care Quickly*.

[3-13] 'Ohana QExA's 2012 rates for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the 2012 results for all composite measures presented in this section will not match the 2012 report.

[3-14] Due to changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting trending results for this measure.

[3-15] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

A comparison of 'Ohana QExA's 2012 scores to its corresponding 2014 scores revealed that 'Ohana QExA scored significantly higher in 2014 than in 2012 on two measures: *Rating of Specialist Seen Most Often* and *Customer Service.*

Conclusions and Recommendations

Based on an evaluation of 'Ohana QUEST's results, the priority areas identified were *Getting Needed Care*, *Getting Care Quickly*, *Rating of Health Plan*, and *Customer Service*. Based on an evaluation of 'Ohana QExA's results, the priority areas identified were *Getting Care Quickly*, *Getting Needed Care*, *Rating of Health Plan*, and *Rating of All Health Care*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in each of these areas.

GETTING NEEDED CARE

Appropriate Health Care Providers—The health plan should ensure that patients are receiving care from physicians most appropriate to treat their conditions. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care timely.

Interactive Workshops—The health plan should engage in promoting health education, health literacy, and preventive health care among its membership. The health plan can develop community-based interactive workshops and educational materials to provide information about general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.

"Max-Packing"—The health plan can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible—a process called "max-packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.

Referral Process—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, may improve communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral and allows providers access to a standardized referral form to ensure that all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors

(e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

Open Access Scheduling—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.

Patient Flow Analysis—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

RATING OF HEALTH PLAN

Alternatives to One-on-One Visits—The health plan should engage in efforts that assist providers in examining and improving their systems' abilities to manage patient demand. As an example, the health plan could test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments. Alternatives to traditional one-on-one, in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.

Health Plan Operations—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

Promote Quality Improvement Initiatives—Implementation of organization-wide QI initiatives is most successful when health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts.

RATING OF ALL HEALTH CARE

Access to Care—The health plan should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The health plan should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols for access to care issues can assist in this process by ensuring issues are handled consistently across all practices. As an example, the health plan could develop standardized protocols and scripts for common occurrences within the provider office setting, such as late patients. Additionally, having a well-written script prepared in the event of an uncommon but expected situation allows staff to work quickly in providing timely access to care while following protocol.

Patient and Family Engagement Advisory Councils—As both patients and families have the direct experience of an illness or health care system, their perspectives can provide significant insight when an organization performs an evaluation of health care processes. As such, the health plan should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource for feedback on health care processes. Involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the health plan and its members. The councils' roles within a health plan organization can vary, and responsibilities may include input into or involvement in program development, implementation, and evaluation; design of materials or tools that support the provider-patient relationship; and marketing of health care services.

CUSTOMER SERVICE

Call Centers—An evaluation of current health plan call center hours and practices may be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center should be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call may assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

Creating an Effective Customer Service Training Program—The health plan should consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators might be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff feels competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

Customer Service Performance Measures—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

UHC CP QUEST and QExA

QUEST Results

Table 3-79 presents the 2014 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response), and overall 2014 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for UHC CP QUEST.[3-16,3-17]

Table 3-79—Adult Medicaid CAHPS Results *for* UHC CP QUEST

Measure	2014 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	47.1%	★
Rating of All Health Care	51.5%	★★★
Rating of Personal Doctor	63.0%	★★
Rating of Specialist Seen Most Often	58.2%+	★+
Composite Measures		
Getting Needed Care	67.7%	★
Getting Care Quickly	70.5%	★
How Well Doctors Communicate	86.4%	★★★
Customer Service	79.0%+	★+

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that UHC CP QUEST scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on no measures.
- At or between the 50th and 74th percentiles on two measures: *Rating of All Health Care* and *How Well Doctors Communicate*.
- At or between the 25th and 49th percentiles on one measure, *Rating of Personal Doctor*.
- Below the 25th percentile on five measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

[3-16] 2014 represents the first year UHC CP QUEST adult members were surveyed; therefore, 2012 rates are not available for the health plan.

[3-17] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

QExA Results

Table 3-80 presents the 2012 and 2014 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response), overall 2014 member satisfaction ratings (i.e., star ratings), and trending results for each of the global ratings and four composite measures for UHC CP QExA.[3-18,3-19,3-20]

Table 3-80—Adult Medicaid CAHPS Results *for* UHC CP QExA

Measure	2012 Rates	2014 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	48.0%	55.8% ▲	★★
Rating of All Health Care	47.5%	53.0%	★★★
Rating of Personal Doctor	67.0%	67.6%	★★★★
Rating of Specialist Seen Most Often	61.4%	63.8%	★★★
Composite Measures			
Getting Needed Care	77.4%	79.4%	★
Getting Care Quickly	76.7%	84.0% ▲	★★★★
How Well Doctors Communicate	89.6%	90.5%	★★★★
Customer Service	71.5%	82.9% ▲	★

▲ indicates the 2014 score is significantly higher than the 2012 score
▼ indicates the 2014 score is significantly lower than the 2012 score

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that UHC CP QExA scored:

- At or above the 90th percentile on no measures.
- At or between the 75th and 89th percentiles on three measures: *Rating of Personal Doctor*, *Getting Care Quickly*, and *How Well Doctors Communicate*.
- At or between the 50th and 74th percentiles on two measures: *Rating of All Health Care* and *Rating of Specialist Seen Most Often.*
- At or between the 25th and 49th percentiles on one measure, *Rating of Health Plan*.
- Below the 25th percentile on two measures: *Getting Needed Care* and *Customer Service*.

[3-18] UHC CP QExA's 2012 rates for all composite measures were recalculated based on the availability of current NCQA national average data; therefore, the 2012 results for all composite measures presented in this section will not match the 2012 report.

[3-19] Due to changes to the *Getting Needed Care* composite measure, caution should be exercised when interpreting trending results for this measure.

[3-20] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

A comparison of UHC CP QExA's 2012 scores to its corresponding 2014 scores revealed that UHC CP QExA scored significantly higher in 2014 than in 2012 on three measures: *Rating of Health Plan*, *Getting Care Quickly*, and *Customer Service.*

Conclusions and Recommendations

Based on an evaluation of UHC CP QUEST's results, the priority areas identified were *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of Health Plan*, and *Rating of Specialist Seen Most Often.* Based on an evaluation of UHC CP QExA's results, the priority areas identified were *Customer Service*, *Getting Needed Care*, and *Rating of Health Plan*. The following are recommendations of best practices and other proven strategies that may be used or adapted by the health plan to target improvement in each of these areas.

RATING OF HEALTH PLAN

Alternatives to One-on-One Visits—The health plan should engage in efforts that assist providers in examining and improving their systems' abilities to manage patient demand. As an example, the health plan might test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of health care services and appointments. Alternatives to traditional one-on-one, in-office visits may assist in improving physician availability and ensuring that patients receive immediate medical care and services.

Health Plan Operations—It is important for health plans to view their organizations as collections of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's health care "products." The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.

Promote Quality Improvement Initiatives—Implementation of organization-wide QI initiatives is most successful when health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Furthermore, progress of QI initiatives should be monitored and reported internally to assess effectiveness of these efforts.

GETTING NEEDED CARE

Appropriate Health Care Providers—The health plan should ensure that patients are receiving care from physicians most appropriate to treat their conditions. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care timely.

Interactive Workshops—The health plan should engage in promoting health education, health literacy, and preventive health care among its membership. The health plan can develop community-based interactive workshops and educational materials to provide information about general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.

"Max-Packing"—The health plan can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit as feasible—a process called "max-packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.

Referral Process—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, may improve communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral and allows providers access to a standardized referral form to ensure that all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plan can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining targeted, potential resolutions.

Electronic Communication —Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.

Open Access Scheduling—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments

weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.

Patient Flow Analysis—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

CUSTOMER SERVICE

Call Centers—An evaluation of current health plan call center hours and practices may be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center should be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call may assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

Creating an Effective Customer Service Training Program—The health plan should consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators might be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff feels competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

Customer Service Performance Measures—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified, as needed.

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plan should work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plan may create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars might include

sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

Telemedicine—Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Furthermore, the local provider is more involved in the consultation process and more informed about the care the patient is receiving.

Child Health Insurance Program (CHIP)

A statewide Child Medicaid CAHPS survey was conducted on a sample of children eligible for CHIP and enrolled in the QUEST health plans. As Hawaii's version of CHIP was implemented as a Medicaid expansion program, these children have the same benefits and access to the same health plan networks as Medicaid-eligible children.

Results

Table 3-81 presents the 2014 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) and overall 2014 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for CHIP.[3-21,3-22]

Table 3-81—Child Medicaid CAHPS Results *for* CHIP

Measure	2013 Rates	2014 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	65.7%	70.7% ▲	★★★★
Rating of All Health Care	61.1%	63.6%	★★★
Rating of Personal Doctor	70.6%	75.0%	★★★★★
Rating of Specialist Seen Most Often	64.2%	62.3%	★
Composite Measures			
Getting Needed Care	82.6%	79.4%	★
Getting Care Quickly	86.6%	86.0%	★
How Well Doctors Communicate	94.5%	94.9%	★★★★
Customer Service	85.0%	83.9%	★

▲ Indicates the 2014 score is significantly higher than the 2013 score.
▼ Indicates the 2014 score is significantly lower than the 2013 score.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

The overall member satisfaction ratings revealed that CHIP scored:

- At or above the 90th percentile on one measure, *Rating of Personal Doctor.*
- At or between the 75th and 89th percentiles on two measures: *Rating of Health Plan* and *How Well Doctors Communicate*.
- At or between the 50th and 74th percentiles on one measure, *Rating of All Health Care.*
- At or between the 25th and 49th percentiles on no measures.

[3-21] NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

[3-22] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

- Below the 25th percentile on four measures: *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

A comparison of CHIP's 2013 scores to its corresponding 2014 scores revealed that CHIP scored significantly higher in 2014 than in 2013 on one measure, *Rating of Health Plan*.

Conclusions and Recommendations

Based on an evaluation of the CHIP results, the priority areas identified were *Customer Service*, *Getting Needed Care*, *Rating of Specialist Seen Most Often*, and *Getting Care Quickly*. The following are recommendations of best practices and other proven strategies that may be used or adapted to target improvement in each of these areas.

CUSTOMER SERVICE

Call Centers—An evaluation of current health plans' call center hours and practices may be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center should be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call may assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

Creating an Effective Customer Service Training Program—The health plans should consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators might be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff feels competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

Customer Service Performance Measures—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified, as needed.

GETTING NEEDED CARE

Appropriate Health Care Providers—The health plans should ensure that patients are receiving care from physicians most appropriate to treat their conditions. Tracking patients to ascertain that they are receiving effective, necessary care from those appropriate health care providers is imperative to assessing quality of care. The health plans should actively attempt to match patients with appropriate health care providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care timely.

Interactive Workshops—The health plans should engage in promoting health education, health literacy, and preventive health care among its membership. The health plans can develop community-based interactive workshops and educational materials to provide information about general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.

"Max-Packing"—The health plans can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit as feasible—a process called "max-packing." Max-packing is a model designed to maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.

Referral Process—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a Web-based system, may improve communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral and allows providers access to a standardized referral form to ensure that all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

RATING OF SPECIALIST SEEN MOST OFTEN

Planned Visit Management—The health plans should work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.

Skills Training for Specialists—The health plans may create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.

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GETTING CARE QUICKLY

Decreasing No-Show Appointments—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The health plans can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plans in determining targeted, potential resolutions.

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Open-Access Scheduling—An open-access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open-access scheduling model includes leaving part of a physician's schedule open for same-day appointments.

Patient Flow Analysis—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

Introduction

This section compares plan-specific EQR activity results for the Hawaii health plans and provides comparisons to statewide scores or to national benchmarks, if available (for HEDIS measures and CAHPS).

Health Plan Comparison

Compliance Monitoring Review

The following table provides information that can be used to compare the Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide and for each health plan for all standards.

Table 4-1—Comparison of Health Plan Compliance Scores

Standard #	Standard Name	AlohaCare QUEST	HMSA QUEST	Kaiser QUEST	'Ohana QUEST	'Ohana QExA	'Ohana CCS	UHC CP QUEST	UHC CP QExA	Statewide/ All Plans
I	Provider Selection	100%	100%	100%	100%	100%	100%	100%	100%	100%
II	Subcontracts and Delegation	95%	100%	88%	100%	100%	100%	100%	100%	98%
III	Credentialing	100%*	100%	100%*	100%*	100%*	100%*	100%	100%	100%
IV	Quality Assessment and Performance Improvement	100%	100%	92%	100%	100%	100%	100%	100%	98%
V	Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%
VI	Practice Guidelines	100%	100%	100%	100%	100%	100%	100%	100%	100%
Overall Compliance Scores:		99%	100%	97%	100%	100%	100%	100%	100%	99%

Scores were calculated by assigning 1 point to *Met* items, 0.5 points to *Partially Met* items, and 0 points to *Not Met* and *NA* items, then dividing the total by the number of applicable items.

*Three new requirements regarding provider disclosure within the Credentialing standard were "*Not Scored*"; therefore, although these plans each received 100 percent as a score, each had findings requiring corrective action. HMSA and UHC CP fully met all requirements of this standard, including the provider disclosure elements.

Across the health plans, performance was quite strong in almost all standards reviewed, and the statewide overall score was 99 percent compliance (all plans/all standards). All eight health plans achieved 100 percent scores in the areas of Provider Selection, Health Information Systems, and Practice Guidelines. Credentialing also was an area of strength for all plans; however, three items regarding new provider disclosure requirements were not met by five of the eight plans and required corrective action. All health plans but two (AlohaCare and Kaiser) scored 100 percent in Subcontracts and Delegation. All health plans but one (Kaiser) scored 100 percent in Quality Assessment and Performance Improvement.

Three plans—HMSA, UHC CP QUEST, and UHC CP QExA—had the highest overall compliance scores this year and required no corrective actions. Similar to last year, AlohaCare and Kaiser were the two lowest-scoring plans, however, at 99 and 97 percent overall respectively, these scores represent strong performance and the few deficiencies requiring correction were not found to be significant areas of weakness. Hawaii's health plans demonstrated their continuing maturity as Medicaid managed care plans through this high level of performance and compliance.

Validation of Performance Measures—HEDIS Compliance Audits

HEDIS Compliance Audits—QUEST Health Plans

Table 4-2 compares each QUEST health plan's compliance with each IS standard reviewed in a HEDIS compliance audit. As demonstrated below, all QUEST health plans were *Fully Compliant* with the IS standards applicable to the measures under the scope of the audit. The health plans were not required to report any HEDIS call center measures; therefore, IS 6.0 was *Not Applicable*.

Table 4-2—Validation of Performance Measures Comparison—QUEST HEDIS Compliance Audit

QUEST Health Plan	Information Systems Review Results						
	IS 1.0—Medical Data	*IS 2.0—Enrollment Data*	*IS 3.0—Provider Data*	*IS 4.0—Medical Record Data*	*IS 5.0—Supplemental Data*	*IS 6.0—Call Center*	*IS 7.0—Data Integration*
AlohaCare	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*
HMSA	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*
Kaiser	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*
'Ohana	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*
UHC CP	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

QUEST HEDIS Performance Measures

Table 4-3 displays the performance measure results for the QUEST health plans' audited HEDIS 2014 measures compared to the MQD Quality Strategy targets for each measure. For most measures, the MQD Quality Strategy target is the national HEDIS Medicaid 75th percentile. For those measures for which a lower rate indicates better performance (e.g., *Well-Child Visits in the First 15 Months of Life—Zero Visits* and *HbA1c Testing—Poor Control)*, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied to these measures.[4-1]

Table 4-3 displays HEDIS 2014 rates under Children's Preventive Care for each QUEST plan. UHC CP did not report a valid rate for 19 of the 21 rates under this domain due to the denominator being smaller than 30. Kaiser reported the highest number of rates meeting the MQD Quality Strategy targets and the national HEDIS 2013 Medicaid 90th percentiles. Kaiser had no rates below the 25th percentile and 17 rates meeting the MQD Quality Strategy targets. Additionally, 16 of these 17 rates also benchmarked above the national Medicaid HEDIS 2013 90th percentiles. The lowest performing plan was 'Ohana—all but one rate (*Childhood Immunization Status--Influenza*) benchmarked below the national HEDIS 2013 Medicaid 25th percentile.

[4-1] For example, because the value associated with the national 10th percentile reflects better performance, HSAG reversed the percentile to become the measure's 90th percentile. Similarly, the value associated with the 25th percentile was reversed to become the 75th percentile. This value also serves as the MQD Quality Strategy target.

Table 4-3—Comparison of HEDIS 2014 QUEST Plan Rates Under Children's Preventive Care					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Childhood Immunization Status					
DTaP	64.23%	75.18%	**90.47%**	47.37%	NA
IPV	79.81%	86.86%	94.12%	73.68%	NA
MMR	77.13%	91.00%	93.90%	47.37%	NA
HiB	80.29%	87.59%	94.12%	73.68%	NA
Hepatitis B	75.43%	89.29%	94.12%	63.16%	NA
VZV	76.16%	89.54%	93.46%	50.00%	NA
Pneumococcal Conjugate	63.26%	77.37%	**88.25%**	47.37%	NA
Hepatitis A	72.75%	64.48%	**93.57%**	63.16%	NA
Rotavirus	54.01%	58.88%	**89.91%**	31.58%	NA
Influenza	48.66%	48.66%	**84.15%**	42.11%	NA
Combination #2	59.85%	71.78%	**88.91%**	36.84%	NA
Combination #3	56.69%	68.37%	**86.36%**	36.84%	NA
Combination #4	53.77%	55.72%	**86.36%**	31.58%	NA
Combination #5	40.63%	48.91%	**82.48%**	18.42%	NA
Combination #6	40.88%	42.82%	**79.49%**	26.32%	NA
Combination #7	39.66%	44.77%	**82.48%**	15.79%	NA
Combination #8	40.15%	38.93%	**79.49%**	23.68%	NA
Combination #9	31.63%	35.52%	**76.05%**	15.79%	NA
Combination #10	31.39%	33.33%	**76.05%**	15.79%	NA
Well-Child Visits in the First 15 Months of Life					
0 Visits[€]	1.70%	1.15%	**0.12%**	15.25%	9.84%
6 or More Visits	64.48%	70.40%	**93.31%**	47.46%	55.74%

[€] A lower rate indicates better performance for this measure. HSAG reversed the national percentiles such that performance level evaluation was consistently applied to this measure as to the other measures.
Note:
Cells with rates meeting the MQD Quality Strategy targets are colored blue. Rates ranking below the national HEDIS 2013 Medicaid 25th percentiles are colored red. Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold **green**.

Table 4-4 displays HEDIS 2014 rates under Women's Health and Care for Chronic Conditions for each QUEST plan. 'Ohana and UHC CP did not report a valid rate for the *Breast Cancer Screening* measure due to the denominator being smaller than 30. Kaiser is considered the highest performing plan for both Women's Health and Care for Chronic Conditions domains. Kaiser had no rates below the 25th percentile and 13 rates meeting the MQD Quality Strategy targets. Additionally, 11 of these 13 rates also benchmarked above the national Medicaid HEDIS 2013 90th percentiles. The lowest performing plan was AlohaCare wherein 13 of the 15 rates in the table below demonstrate benchmarks below the national HEDIS 2013 Medicaid 25th percentiles.

Table 4-4—Comparison of HEDIS 2014 QUEST Plan Rates Under Women's Health and Care for Chronic Conditions					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Chlamydia Screening in Women					
16–20 Years	44.03%	61.51%	66.26%	48.24%	38.33%
21–24 Years	46.93%	66.40%	**74.07%**	51.54%	59.15%
Total	45.61%	64.02%	**69.91%**	50.23%	52.97%
Breast Cancer Screening					
Breast Cancer Screening	28.28%	64.69%	**83.08%**	NA	NA
Controlling High Blood Pressure					
<140/90 mm Hg	43.31%	45.99%	**83.94%**	50.76%	43.10%
Comprehensive Diabetes Care					
HbA1c Testing	77.78%	83.73%	**94.36%**	83.58%	79.81%
HbA1c Poor Control (>9.0%)[€]	59.37%	49.73%	34.39%	56.72%	62.02%
HbA1c Control (<8.0%)	31.34%	42.23%	51.16%	34.70%	32.69%
HbA1c Control (<7.0%)	18.26%	27.90%	31.72%	25.57%	20.37%
Eye Exam	51.08%	57.40%	**71.90%**	50.75%	62.98%
LDL-C Screening	69.65%	80.80%	**93.07%**	78.73%	75.00%
LDL-C Control	26.70%	30.90%	**65.69%**	29.48%	24.04%
Nephropathy	72.80%	79.34%	**91.33%**	79.85%	78.85%
Blood Pressure Control (<140/80)	33.00%	25.78%	**62.41%**	41.04%	31.25%
Blood Pressure Control (<140/90)	51.24%	41.50%	**83.76%**	63.06%	49.52%

[€] A lower rate indicates better performance for this measure. HSAG reversed the national percentiles such that performance level evaluation was consistently applied to this measure as to the other measures.

Note: Cells with rates meeting the MQD Quality Strategy targets are colored blue. Rates ranking below the national HEDIS 2013 Medicaid 25th percentiles are colored red. Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold **green**.

HEDIS Compliance Audits—QExA Health Plans

Table 4-5 compares each QExA health plan's compliance with each IS standard reviewed in a HEDIS compliance audit. As demonstrated below, the QExA health plans were *Fully Compliant* with the IS standards applicable to the measures under the scope of the audit. The health plans were not required to report any HEDIS call center measures; therefore, IS 6.0 was *Not Applicable*.

Table 4-5—Validation of Performance Measures Comparison—QExA HEDIS Compliance Audit							
QExA Health Plan	**Information Systems Review Results**						
	IS 1.0 – Medical Data	*IS 2.0 – Enrollment Data*	*IS 3.0 – Provider Data*	*IS 4.0 – Medical Record Data*	*IS 5.0 – Supplemental Data*	*IS 6.0 – Call Center*	*IS 7.0 – Data Integration*
'Ohana	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*
UHC CP	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

QExA HEDIS Performance Measures

Table 4-6 displays the performance measure results for the QExA health plans' audited HEDIS 2014 measures compared to the MQD Quality Strategy targets for each measure. For most measures, the MQD Quality Strategy target is the national HEDIS Medicaid 75th percentile. For those measures wherein a lower rate indicates better performance (e.g., *HbA1c Poor Control, Ambulatory Care—ED Visits, Plan All-Cause Readmissions)*, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied to these measures.[4-2] For the *Inpatient Utilization* and *Plan All-Cause Readmissions* measures, results are only compared between the two QExA plans as there were no established MQD Quality Strategy targets.

Table 4-6 displays HEDIS 2014 rates under Care for Chronic Conditions and *All-Cause Readmissions* for each QExA plan. UHC CP's performance was comparable to 'Ohana's. Similar to 'Ohana, UHC CP had one rate ranked above the national HEDIS 2013 Medicaid 90th percentile. However, UHC CP had seven rates (i.e., two more rates than 'Ohana) meeting the MQD Quality targets. At the same time, UHC CP had two rates performing below the national HEDIS 2013 Medicaid 25th percentile, whereas 'Ohana had no rates performing below the national 25th percentile.

[4-2] For example, because the value associated with the national 10th percentile reflects better performance, HSAG reversed the percentile to become the measure's 90th percentile. Similarly, the value associated with the 25th percentile was reversed to become the 75th percentile. This value also serves as the MQD Quality Strategy target.

Table 4-6—Comparison of HEDIS 2014 QExA Plan Rates Under Care for Chronic Conditions and All-Cause Readmissions		
	'Ohana	UHC CP
Controlling High Blood Pressure		
<140/90 mm Hg	60.50%	45.48%
Comprehensive Diabetes Care		
HbA1c Testing	88.11%	84.20%
HbA1c Poor Control (>9.0%)[€]	39.16%	34.38%
HbA1c Control (<8.0%)	52.05%	58.16%
HbA1c Control (<7.0%)	32.93%	41.08%
Eye Exam	63.54%	62.85%
LDL-C Screening	83.32%	81.25%
LDL-C Control	43.06%	**45.49%**
Nephropathy	**86.51%**	85.24%
Blood Pressure Control (<140/80)	40.66%	38.19%
Blood Pressure Control (<140/90)	59.74%	50.87%
Plan All-Cause Readmissions (PCR)		
PCR Total[€]	16.20%	13.56%

[€] A lower rate indicates better performance for this measure. HSAG reversed the national percentiles such that performance level evaluation was consistently applied to this measure as to the other measures. For the *HbA1c Poor Control* indicator, the MQD Quality Strategy target is the national HEDIS 2013 Medicaid 75th percentile. For the *Plan All-Cause Readmissions* measure, there was no MQD Quality Strategy target established. The rates were compared to the national HEDIS 2013 Medicare benchmarks.

Note: Cells with rates meeting the MQD Quality Strategy targets are colored blue. Rates ranking below the national HEDIS 2013 Medicaid 25th percentiles are colored red. Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold **green**.

Table 4-7 displays HEDIS 2014 rates under Access to Care and Utilization for each QExA plan. MQD Quality Strategy targets are not available for the Inpatient Utilization measure. For the Adults' Access to Preventive/Ambulatory Health Services and Ambulatory Care measures, UHC CP performed slightly better than 'Ohana in that, while both plans performed equally well in the Adults' Access measure and the Outpatient Visits indicator under Ambulatory Care, 'Ohana's ED Visits rate was below the national 25th percentile.

Table 4-7—Comparison of HEDIS 2014 QExA Plan Rates Under Access to Care and Utilization		
	‘Ohana	UHC CP
Adults’ Access to Preventive/Ambulatory Health Services		
20–44 years	86.05%	87.47%
45–64 years	**92.15%**	**93.61%**
65+ years	**95.06%**	**96.50%**
Total	**91.87%**	**94.07%**
Ambulatory Care		
ED Visits/1,000[€]	76.11	63.70
Outpatient Visits/1,000	**748.03**	**798.97**
Inpatient Utilization—General Hospital/Acute Care^		
Total Inpatient Discharges/1,000	23.32	19.18
Total Inpatient Days/1,000	183.91	183.98
Total Inpatient Average Length of Stay	7.89	9.59
Total Medicine Discharges/1,000	16.04	15.00
Total Medicine Days/1,000	90.71	137.52
Total Medicine Average Length of Stay	5.66	9.17
Total Surgery Discharges/1,000	7.00	4.05
Total Surgery Days/1,000	92.29	46.11
Total Surgery Average Length of Stay	13.18	11.37
Total Maternity Discharges/1,000	43.42	0.25
Total Maternity Days/1,000	1.41	0.68
Total Maternity Average Length of Stay	3.24	2.74

[€]A lower rate indicates better performance for this measure. HSAG reversed the national percentiles such that performance level evaluation was consistently applied to this measure as to the other measures.
^ Results are presented for informational purposes only. There were no established MQD Quality Strategy targets for this measure. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.
Note: Cells with rates meeting the MQD Quality Strategy targets are colored blue. Rates ranking below the national HEDIS 2013 Medicaid 25th percentiles are colored red. Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold **green**.

For the Inpatient Utilization measure, both plans had comparable utilization rates for services under the Total Inpatient category. However, ‘Ohana had much higher utilization in the Surgery and Maternity categories and UHC CP had higher utilization in the Medicine category. Because this utilization measure does not take into account each QExA plan’s member demographic and clinical characteristics, interpretation of the utilization rates in the context of performance is cautioned.

Performance Measure Validation—'Ohana CCS Program

Because this behavioral health carve-out program is unique in Hawaii, no comparisons can be made to the other Medicaid health plans. The CCS HEDIS measures can be compared to HEDIS national benchmarks, but as the program was only operational for nine months during the measurement year (2013), caution should be exercised when interpreting these results. Audited rates for both HEDIS and non-HEDIS measures should be treated as baseline performance used for comparison to future years' rates.

Validation of Performance Improvement Projects

Validity of Performance Improvement Projects for QUEST Health Plans

HSAG conducted a review of two PIPs for each of the five QUEST plans—AlohaCare, HMSA, Kaiser, ‘Ohana, and UHC CP. For each QUEST plan, Table 4-8 shows the aggregate number of applicable evaluation elements that were scored *Met* for each stage and the combined overall percentage of evaluation elements *Met* for both PIPs.

Table 4-8—2014 Performance Improvement Project Validation Results Comparison by Health Plan (N=10 PIPs)

Stage	Activities	Percentage of Applicable Elements Scored *Met*				
		QUEST Health Plans				
		AlohaCare	HMSA	Kaiser	‘Ohana	UHC CP
Design	Activities I–VI	100%	100%	100%	100%	100%
Implementation	Activities VII–VIII	100%	100%	100%	100%	100%
Outcomes	Activities IX–X	25%	63%	63%	*Not Assessed*	*Not Assessed*
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**90%**	**95%**	**94%**	**100%**	**100%**

All five QUEST health plans received a *Met* validation status. Additionally, all five QUEST health plans met 100 percent of the requirements for all activities within the Design and Implementation stages. Overall, the health plans designed scientifically sound PIPs supported by key research principles. The technical design of each PIP was sufficient to measure and monitor PIP outcomes associated with the health plans’ improvement strategies. The solid design of the PIPs allowed the successful progression to the next stage of the PIP process. Two QUEST health plans did not progress to the Outcomes stage. For the QUEST health plans that progressed to the Outcomes stage, none received 100 percent in this stage because not all study indicators demonstrated improvement and/or statistically significant improvement over baseline.

Validity of Performance Improvement Projects for QExA Health Plans and the CCS Program

HSAG conducted a review of two PIPs for each of the two QExA plans—’Ohana and UnitedHealthcare Community Plan (UHC CP). HSAG also validated two PIPs for the ‘Ohana CCS program. For each plan, Table 4-9 shows the aggregate number of applicable evaluation elements that were scored *Met* for each stage and the combined overall percentage of evaluation elements *Met* for both PIPs.

Table 4-9—2014 Performance Improvement Project Validation Results Comparison by Health Plan (N=6 PIPs)				
Stage	Activities	Percentage of Applicable Elements Scored *Met*		
		QExA Health Plans		CCS Program
		'Ohana	UnitedHealthcare Community Plan	'Ohana CCS
Design	Activities I–VI	100%	100%	100%
Implementation*	Activities VII–VIII	100%	100%	100%
Outcomes	Activities IX-X	100%	78%	*Not Assessed*
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**100%**	**97%**	**100%**
* The CCS PIPs did not progress past Activity VII.				

Both QExA plans adequately documented the necessary validation components for their PIPs in the Design and Implementation stages. Overall, the health plans designed scientifically sound PIPs supported by key research principles. The technical design of each PIP was sufficient to measure and monitor PIP outcomes associated with the health plans' improvement strategies. The solid design of the PIPs allowed the successful progression to the next stage of the PIP process. All QExA PIPs received a *Met* validation status. The UHC CP *Diabetes Care* PIP has not achieved statistically significant improvement over baseline; therefore, only 78 percent of the evaluation elements in the Outcomes stage received a *Met* score.

The CCS health plan PIPs also received 100 percent in the Design and Implementation stages. Both PIPs received a *Met* validation status. These PIPs had not yet progressed to the Outcomes stage for the 2014 validation.

QUEST Performance Improvement Projects Outcomes

Table 4-10 and Table 4-11 display the outcome data for the QUEST health plans' PIPs. Detailed study indicator descriptions and rates for each measurement period are provided in Section 3.

Table 4-10—2014 Performance Improvement Project Outcomes for *All-Cause Readmissions* Comparison by QUEST Health Plan			
PIP Topic and Number (N) of Indicators	Comparison to Study Indicator Results From Prior Measurement Period	Comparison to Study Indicator Results From Baseline	Sustained Improvement
	Improvement	Statistically Significant Improvement	
AlohaCare			
All-Cause Readmissions (N=1)	No	No	*Not Assessed*
HMSA			
All-Cause Readmissions (N=1)	Yes	Yes	*Not Assessed*
Kaiser			
All-Cause Readmissions (N=1)	No	No	*Not Assessed*
'Ohana			
All-Cause Readmissions (N=1) *	*Not Applicable*	*Not Applicable*	*Not Assessed*
UHC CP			
All-Cause Readmissions (N=1) *	*Not Applicable*	*Not Applicable*	*Not Assessed*

* A comparison of the study indicator results could not be performed during the 2014 validation because only baseline results were reported.

For the *All-Cause Readmissions* PIPs, 'Ohana and UHC CP reported baseline data for calendar year 2013; therefore, results comparisons could not be made during the 2014 validation. The other QUEST health plans reported first remeasurement results. AlohaCare and Kaiser had increases in the rate of readmissions for the 2014 validation. For this study indicator, a decrease represents improvement. HMSA demonstrated statistically significant improvement over baseline in the rate of readmissions for the 2014 validation. Another measurement period result is required to assess for sustained improvement because the study indicators must achieve statistically significant improvement over baseline and report a subsequent measurement period before they can be assessed for sustained improvement.

Table 4-11—2014 Performance Improvement Project Outcomes for *Diabetes Care* PIP Comparison by QUEST Health Plan			
PIP Topic and Number (N) of Indicators	Comparison to Study Indicator Results From Prior Measurement Period	Comparison to Study Indicator Results From Baseline	Sustained Improvement
	Improvement	Statistically Significant Improvement	
AlohaCare			
Diabetes Care (N=4)	2/4	0/4	*Not Assessed*
HMSA			
Diabetes Care (N=3)	1/3	0/3	*Not Assessed*
Kaiser			
Diabetes Care (N=1)	1/1	1/1	*Not Assessed*
'Ohana			
Diabetes Care (N=2)*	*Not Applicable*	*Not Applicable*	*Not Assessed*
UHC CP			
Diabetes Care (N=2)*	*Not Applicable*	*Not Applicable*	*Not Assessed*

* A comparison of the study indicator results could not be performed during the 2014 validation because only baseline results were reported.

For the *Diabetes Care* PIPs, 'Ohana and UHC CP reported baseline data for calendar year 2013; therefore, results comparisons could not be made during the 2014 validation. The other QUEST health plans reported first remeasurement results. AlohaCare demonstrated improvement in half of its study indicators for the *Diabetes Care* PIP. The improvement was not statistically significant. HMSA had improvement in one of three study indicators that was not statistically significant. Kaiser demonstrated statistically significant improvement in its *Diabetes Care* PIP study indicator. The QUEST *Diabetes Care* PIPs were not assessed for sustained improvement in the 2014 validation because the study indicators must achieve statistically significant improvement over baseline and report a subsequent measurement period before they can be assessed for sustained improvement.

QExA Performance Improvement Projects

Table 4-12 displays the outcome data for the QExA and CCS health plans' PIPs for 2014. Detailed study indicator descriptions and rates for each measurement period are provided in Section 3.

Table 4-12—2014 Performance Improvement Project Outcomes Comparison by QExA and CCS Health Plans			
PIP Topic and Number (N) of Indicators	Comparison to Study Indicator Results From Prior Measurement Period	Comparison to Study Indicator Results From Baseline	Sustained Improvement
	Improvement	Statistically Significant Improvement	
'Ohana QExA			
Assessing the Documentation of Body Mass Index (BMI) (N=3)	3/3	3/3	1/3
Diabetes Care (N=3)	3/3	3/3	1/3
'Ohana CCS			
*Follow-up After Hospitalization for Mental Illness (N=2)**	*Not Applicable*	*Not Applicable*	*Not Assessed*
*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (N=2)**	*Not Applicable*	*Not Applicable*	*Not Assessed*
UHC CP			
Assessing the Documentation of Body Mass Index (BMI) (N=2)	2/2	2/2	2/2
Diabetes Care (N=2)	2/2	0/2	*Not Assessed*

* A comparison of the study indicator results could not be performed during the 2014 validation because only baseline results were reported.

The 'Ohana CCS PIPs included baseline results; therefore, no assessments for real or sustained improvement could be completed for the 2014 validation. 'Ohana QExA achieved statistically significant improvement over baseline for all study indicators, and sustained improvement was achieved for one study indicator in each PIP for the 2014 validation. Two study indicators in each PIP were not yet assessed for sustained improvement because another measurement period is required. The UHC CP *BMI* PIP achieved sustained improvement in both study indicators for the 2014 validation. The UHC CP *Diabetes Care* PIP reported Remeasurement 3 results in the 2014 validation and has not yet achieved statistically significant improvement over baseline for either study indicator. Study indicators must achieve statistically significant improvement over baseline and report a subsequent measurement period before they can be assessed for sustained improvement.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey

Top-Box Comparisons

QUEST HEALTH PLANS

Table 4-13 presents the question summary rates and global proportions for each QUEST health plan and the QUEST aggregate.[4-3]

Table 4-13—Comparison of 2014 QUEST CAHPS Results

	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP	QUEST Aggregate
Global Ratings						
Rating of Health Plan	54.4%	55.2%	67.8% ↑	51.4%	47.1% ↓	56.2%
Rating of All Health Care	45.6% ↓	46.8% ↓	66.5% ↑	49.1%	51.5%	52.7%
Rating of Personal Doctor	63.4%	60.6%	74.0% ↑	62.2%	63.0%	65.1%
Rating of Specialist Seen Most Often	65.7%	59.2%	60.5%	63.7%	58.2%+	61.3%
Composite Measures						
Getting Needed Care	74.3%	77.7%	82.2% ↑	72.4%	67.7% ↓	75.8%
Getting Care Quickly	76.1%	77.7%	81.1% ↑	74.6%	70.5% ↓	76.5%
How Well Doctors Communicate	90.2%	88.7%	94.7% ↑	90.2%	86.4%	90.3%
Customer Service	79.1%	84.3%+	88.7%+	83.4%	79.0%+	82.6%
Shared Decision Making	52.7%	48.0%	50.3%	50.5%	53.7%+	50.9%
Individual Item Measures						
Coordination of Care	79.6%+	78.6%	85.6%	79.2%	82.1%+	81.1%
Health Promotion and Education	73.3%	72.2%	71.7%	76.3%	72.2%	72.9%

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.

Due to changes to the *Shared Decision Making* composite measure and the *Health Promotion and Education* individual item measure, 2013 NCQA national averages are not available for these measures; therefore, comparisons to NCQA national averages could not be performed for 2014.

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2013 NCQA national adult Medicaid average.

↑ Indicates that the score is higher than the QUEST aggregate by a statistically significant degree.
↓ Indicates that the score is lower than the QUEST aggregate by a statistically significant degree.

[4-3] The QUEST aggregate results were derived from the combined results of the QUEST health plans.

Comparison of the QUEST AlohaCare, HMSA, Kaiser, ‘Ohana, UHC CP, and aggregate scores to the 2013 NCQA national adult Medicaid average revealed the following:

- The QUEST aggregate scores were above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care.*
- AlohaCare scored above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Coordination of Care.*
- HMSA did not score above the NCQA national adult Medicaid average on any of the nine comparable measures.
- Kaiser scored above the NCQA national adult Medicaid average on seven of the nine comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care.*
- ‘Ohana scored above the NCQA national adult Medicaid average on two of the nine comparable measures: *How Well Doctors Communicate* and *Coordination of Care.*
- UHC CP scored above the NCQA national adult Medicaid average on two of the nine comparable measures: *Rating of All Health Care* and *Coordination of Care.*

Comparison of the QUEST AlohaCare, HMSA, Kaiser, ‘Ohana, and UHC CP scores to the QUEST aggregate scores revealed the following:

- AlohaCare scored significantly lower than the QUEST aggregate on one measure: *Rating of All Health Care*.
- HMSA scored significantly lower than the QUEST aggregate on one measure: *Rating of All Health Care.*
- Kaiser scored significantly higher than the QUEST aggregate on six measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate.*
- ‘Ohana’s scores were not significantly different from the QUEST aggregate on any measures.
- UHC CP scored significantly lower than the QUEST aggregate on three measures: *Rating of Health Plan*, *Getting Needed Care*, and *Getting Care Quickly*.

QExA HEALTH PLANS

Table 4-14 presents the question summary rates and global proportions for each QExA health plan and the QExA aggregate.[4-4]

Table 4-14—Comparison of 2014 QExA CAHPS Results

	'Ohana	UHC CP	QExA Aggregate
Global Ratings			
Rating of Health Plan	50.3%	55.8%	53.1%
Rating of All Health Care	44.7% ↓	53.0% ↑	48.8%
Rating of Personal Doctor	64.2%	67.6%	66.0%
Rating of Specialist Seen Most Often	69.9%	63.8%	66.5%
Composite Measures			
Getting Needed Care	79.2%	79.4%	79.3%
Getting Care Quickly	77.8% ↓	84.0% ↑	81.0%
How Well Doctors Communicate	89.0%	90.5%	89.8%
Customer Service	87.5%	82.9%	85.1%
Shared Decision Making	49.1%	52.5%	50.8%
Individual Item Measures			
Coordination of Care	85.2%	85.7%	85.5%
Health Promotion and Education	80.1%	76.5%	78.3%

Due to changes to the *Shared Decision Making* composite measure and the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for these measures; therefore, comparisons to NCQA national averages could not be performed for 2014.

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2013 NCQA national adult Medicaid average.

↑ Indicates that the score is higher than the QExA aggregate by a statistically significant degree.
↓ Indicates that the score is lower than the QExA aggregate by a statistically significant degree.

Comparison of the QExA 'Ohana, UHC CP, and aggregate scores to the 2013 NCQA national adult Medicaid average revealed the following:

- The QExA aggregate scores were above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Coordination of Care*.

[4-4] The QExA aggregate results were derived from the combined results of the QExA health plans.

- ‘Ohana scored above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Customer Service*, and *Coordination of Care.*
- UHC CP scored above the NCQA national adult Medicaid average on five of the nine comparable measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Coordination of Care.*

A comparison of the QExA plans revealed statistically significant differences between the two plans on two measures: *Rating of All Health Care* and *Getting Care Quickly*.

CHILD HEALTH INSURANCE PROGRAM (CHIP) STATEWIDE SURVEY

Table 4-15 presents the question summary rates and global proportions for the Hawaii CHIP population.

Table 4-15—Comparison of 2014 CHIP CAHPS Results

	2014 CHIP
Global Ratings	
Rating of Health Plan	70.7%
Rating of All Health Care	63.6%
Rating of Personal Doctor	75.0%
Rating of Specialist Seen Most Often	62.3%
Composite Measures	
Getting Needed Care	79.4%
Getting Care Quickly	86.0%
How Well Doctors Communicate	94.9%
Customer Service	83.9%
Shared Decision Making	53.6%
Individual Item Measures	
Coordination of Care	83.1%
Health Promotion and Education	70.1%

Due to changes to the *Shared Decision Making* composite measure and the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for these measures; therefore, comparisons to NCQA national averages could not be performed for 2014.

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2013 NCQA national child Medicaid average.

Comparison of the CHIP scores to the 2013 NCQA national child Medicaid average revealed the following:

- Hawaii’s CHIP scored above the NCQA national child Medicaid average on four of the nine comparable measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care.*

NCQA Comparisons

QUEST HEALTH PLANS[4-5]

Table 4-16 presents the overall member satisfaction ratings for the QUEST aggregate and each health plan on each of the four global ratings.

Table 4-16—NCQA Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
QUEST Plan Aggregate	★★★	★★★	★★★★	★★
AlohaCare	★★	★★	★★★★	★★★
HMSA	★★★	★★	★★	★
Kaiser	★★★★★	★★★★★	★★★★★	★
'Ohana	★	★★	★★★	★★★
UHC CP	★	★★★	★★	★+

Note: CAHPS scores with fewer than 100 respondents are denoted with a plus symbol (+). If the health plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Table 4-17 presents the overall member satisfaction ratings for the QUEST aggregate and each health plan on the four composite measures.

Table 4-17—NCQA Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
QUEST Plan Aggregate	★	★	★★★★	★
AlohaCare	★	★	★★★★	★
HMSA	★	★	★★★	★+
Kaiser	★★	★★★	★★★★★	★★★+
'Ohana	★	★	★★★★	★
UHC CP	★	★	★★★	★+

Note: CAHPS scores with fewer than 100 respondents are denoted with a plus symbol (+). If the health plan had fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

[4-5] Because NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, star ratings cannot be assigned.

QExA Health Plans[4-6]

Table 4-18 presents the overall member satisfaction ratings for the QExA aggregate and each health plan on each of the four global ratings.

Table 4-18—NCQA Comparisons: Global Ratings

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
QExA Plan Aggregate	★★	★★	★★★	★★★★
'Ohana	★	★	★★★	★★★★★
UHC CP	★★	★★★	★★★★	★★★

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Table 4-19 presents the overall member satisfaction ratings for the QExA aggregate and each health plan on each of the four composite measures.

Table 4-19—NCQA Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
QExA Plan Aggregate	★	★★	★★★★	★
'Ohana	★	★	★★★	★★
UHC CP	★	★★★★	★★★★	★

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

[4-6] Because NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, star ratings cannot be assigned.

CHIP[4-7, 4-8]

Table 4-20 presents the overall member satisfaction ratings for the Hawaii CHIP population on each of the four global ratings.

Table 4-20—NCQA Comparisons: Global Ratings

Population	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
Hawaii **CHIP**	★★★★	★★★	★★★★★	★

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Table 4-21 presents the overall member satisfaction ratings for the CHIP population on each of the four composite measures.

Table 4-21—NCQA Comparisons: Composite Measures

Population	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Hawaii **CHIP**	★	★	★★★★	★

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

[4-7] Because NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, star ratings cannot be assigned.

[4-8] NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

5. Assessment of Follow-Up to Prior Year Recommendations

Introduction

This section of the annual report presents an assessment of how effectively the QUEST and QExA health plans addressed the improvement recommendations made by HSAG in the prior year (2013) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, CAHPS, and the provider survey. The CCS program was not reviewed by the EQRO in 2013 as it was a new plan as of March 1, 2013, and, therefore, neither participated in EQR activities nor received EQRO recommendations last year.

With the exception of compliance monitoring, the improvements and corrective actions related to the EQR activity recommendations were self-reported by each health plan. HSAG reviewed this information to assess the degree to which the activities were responsive to the improvement opportunities.

2013 Compliance Monitoring Review

Formal follow-up reevaluations of the health plans' corrective actions, to address the deficiencies identified in the 2013 compliance reviews, were completed by HSAG in late 2013 and early 2014. The specific compliance review findings and recommendations were reported in the 2013 EQR Report of Results and were related to the federal managed care requirements and MQD contract standards for access and availability, coverage and authorization, member information, member rights and responsibilities, grievance system, and coordination and continuity of care. As appropriate, HSAG conducted technical assistance for the plans and conducted the follow-up assessments of compliance either telephonically or on-site as indicated by the significance or number of deficiencies. All health plans were found to have sufficiently addressed and corrected their deficiencies through implementation of corrective action plans and were found to be in full compliance with requirements during the reevaluations conducted by HSAG.

In addition, due to the large number of findings across all plans related to member notices and processing of grievances and appeals, the MQD hosted an initiative to develop standardized template letters and notices of action for implementation by all plans. The MQD provided HSAG and the health plans an opportunity to review and comment on the drafts as part of the MQD's development process. The standardized templates were distributed to the plans by the MQD in July 2014 for the plans' customization and use in fulfilling the requirements of the federal coverage/authorization and grievance system standards and to ensure continued compliance with these requirements.

2013 Validation of Performance Measures—HEDIS Compliance Audits

AlohaCare

AlohaCare's HEDIS Performance Measures Recommendations

- AlohaCare should ensure that claims and encounter data are complete and accurate and that opportunities for use of supplemental data sources are explored. AlohaCare should continue to educate providers on the importance of submitting encounter data and should employ sanctions for noncompliant providers. AlohaCare should also review the completeness of its laboratory data.
- AlohaCare should implement quality improvement strategies to ensure complete and accurate hybrid data. More specifically, AlohaCare should review the wording associated with the provider medical record request documentation used by its vendor to procure records to ensure that the correct time frame is requested and enforced. In addition to reviewing the vendor's record procurement and abstraction reports, AlohaCare should implement additional policies and procedures related to vendor oversight. The oversight must include proper monitoring of both record procurement and accuracy of the vendor's abstraction. AlohaCare should design a tracking mechanism to ensure that monitoring and oversight of its MRR delegate is performed throughout the medical record review process and is documented, with special attention during the early procurement and abstraction phase. To ensure abstraction accuracy, AlohaCare may want to consider assigning a dedicated second-level senior reviewer to validate abstraction results across all measures and provide feedback and retraining to the vendor.
- Because the NCQA timeline and requirements regarding the use of supplemental databases have become stricter, AlohaCare must begin its supplemental data collection sooner and monitor any NCQA updates regarding supplemental database specifications regularly to ensure compliance.
- AlohaCare should educate members on their disease conditions and on overall health and wellness. AlohaCare should also investigate reasons for low outpatient visit rates among members.

Improvement Activities Implemented:

- Regarding data completeness, AlohaCare reported confidence that, because only a few providers are paid by capitation, complete encounter data are being received. AlohaCare receives laboratory results data directly from its two largest laboratory services providers. The health plan has initiated a strategy for 2014 to improve completeness of claims/encounter and laboratory data by adding supplemental databases from electronic health record (EHR) files. EHR files will contain more complete data on laboratory results, immunizations, and other elements not included on claims. AlohaCare had included a supplemental EHR file from its largest provider in its HEDIS measure collection/calculation process for 2014 (for 2013 data) and plans to expand this process to as many as 10 additional large providers for the 2015 HEDIS data collection.
- AlohaCare also implemented several initiatives to improve hybrid data collection in 2014:
  - Based on its prior year (2013) experience with its medical record review (MRR) vendor, AlohaCare required that the vendor provide a different account management team and take

actions to prevent the problems with retrieval rates and abstraction accuracy encountered in the prior year.

- AlohaCare updated record request letters to providers with clearer instructions about the record information to submit for each requested measure.
- AlohaCare performed weekly oversight of the vendor's performance through receipt of detailed performance reports on record retrieval, abstraction completion and accuracy, and discussions during weekly conference calls.
- AlohaCare staff performed over-read on vendor abstraction results across all measures and provided early and frequent feedback on findings to the vendor's abstraction team.

- AlohaCare was proactive in submitting supplemental databases before NCQA deadlines. Supplemental data were submitted for laboratory results, childhood immunizations, and chlamydia screening and included an EHR file from its largest provider. AlohaCare plans to continue to focus on timely submission of supplemental databases for 2015.

HMSA

HMSA's HEDIS Performance Measures Recommendations

- HMSA should continue to monitor claims and encounter data completeness and work to ensure laboratory data are received. Many of the *Comprehensive Diabetes Care (CDC)* indicators require laboratory data, so HMSA should ensure that these are being received and, if not, should develop ways to obtain them.
- Educating members about both their specific disease conditions and overall health and wellness is crucial to holding them accountable for their health and well-being. Provider education about clinical practice guidelines could be useful to ensure providers are aware of the required services a member needs. Also, HMSA should consider tracking and monitoring the submitted service data to help identify gaps in data completeness.

Improvement Activities Implemented:

- Member Education
  - HMSA stated it believes that the best practice for member education is to have information emanate from the patient's provider. To that end, HMSA has made member education information available to providers. The health plan revamped the provider order form for materials to describe better the contents and expected benefits of each offering. Additionally, HMSA informed providers of available diabetes education classes in the January 2014 Provider Update.
- Clinical Practice Guidelines
  - In October 2013, HMSA updated the diabetes-related clinical practice guidelines, utilizing the American Association of Clinical Endocrinologists, American Diabetes Association, American Thyroid Association, The Endocrine Society, and the U.S. Preventive Services Task Force. Providers were informed of this update via the HMSA Provider Update. In 2013, mailers reinforcing the clinical needs expressed in the guidelines were sent to members and providers on a member-specific level.
  - To support tracking and monitoring of service data to help identify gaps in data completeness, HMSA makes available for its providers an online tool called Cozeva. This tool tracks and displays service data to identify gaps in care. The tool allows providers to add supplemental data to ensure data completeness.

Kaiser

Kaiser's HEDIS Performance Measures Recommendations

- While Kaiser's overall performance was high, areas for improvement still existed, especially for HbA1c Control (<7.0%), where the rate was below the HEDIS 2012 Medicaid 50th percentile.

Improvement Activities Implemented:

Kaiser reported that diabetes (HbA1c Control) has been a renewed priority in the region for 2013-2014. In addition to continuing its current processes, Kaiser initiated trial of some new processes. Both are described as follows:

Kaiser's Current (Continuing) Processes

- Panel Support Tool (PST) is the tool used consistently by the PCP team to flag needed prevention and chronic disease gaps for each member at the point of care. This includes labs that are due (e.g., A1c, LDL) and recommended adjustments in medications for labs that are not at goal (e.g., adjustment of orals or addition of insulin for A1c or LDL labs that are not at goal). The PST is also used for population management to allow the PCP team to outreach to members who are not coming in to the clinic.
- Diabetes Education Classes are still available to all pre-diabetes and diabetes members. PCP teams refer members to these classes to receive education about diabetes, including information about diet, exercise, medications, and labs, among other topics. Classes are taught by health educators, dieticians, and nurses and content includes self-monitoring with glucometers and insulin starts if needed. Nurses continue to be available to the PCP team to provide urgent education about glucometers and insulin starts.
- KP Health Connect (KPHC), the electronic medical record system, continues to be extremely useful in managing lab results for diabetes members. It allows for timely receipt of lab results in the PCP in-basket, flagging of critical values and labs that were not done, and exchange of information among PCP team and central nursing/pharmacy support.
- Patient Support Services (PSS) continues to be the central population management support for the PCP team for diabetes and cardiovascular disease members. This team of nurses and pharmacists helps contact members due for labs and/or medication pick-up and assists PCP teams with titrating medications to bring members to goal.
- Automated batch ordering of labs every six months continues for members with diabetes. Automated recorded reminders are used for members with overdue labs.
- Within Kaiser's *Diabetes LDL* PIP, to provide the additional assistance to the PCP team, PSS has been focusing outreach toward Medicaid diabetes members, regardless of whether or not the member has been referred to PSS. In addition to the reminder calls about labs, PSS also assists in titrating medications to get A1c and LDL levels to goal.

Kaiser's New Processes

- To increase medication compliance, PSS staff members strive to ensure that Medicaid diabetes members receive a three-month supply of medications.

- A new process to address poor A1c control of >9 was begun in mid-2012. More recently, this effort has expanded to proactively reach members with A1c control of >8. Dedicated nursing and pharmacy PSS staff members assist PCP teams serving diabetes members with poorly controlled A1c. They contact members frequently and titrate medications (orals and/or insulin) aggressively based on glucometer readings. Kaiser's goal is to follow up with these members and titrate their medications in a timelier manner and improve the percentage of A1c <7.

'Ohana

'Ohana's HEDIS Performance Measures Recommendations

- To improve performance on measures in the Care for Chronic Conditions domain, 'Ohana should ensure that all service data, including lab results, are being received from its contracted providers and FQHCs.
- Educating members about their disease conditions will help to ensure they are aware of services recommended to treat their conditions and maintain good health. Provider education about practice guidelines and standards of care for different disease states may be necessary.
- 'Ohana's rate for ED visits ranked below both the MQD Quality Strategy target and the 50th percentile. While in general the QExA health plans may enroll sicker individuals with more chronic conditions than the QUEST health plans enroll, it is still recommended that 'Ohana review the top diagnoses for these visits and determine if additional disease management programs or other interventions could be implemented to decrease any inappropriate use of the ED.

Improvement Activities Implemented:

'Ohana's Quality Improvement Intervention Workgroup (QIIW) and Quality Improvement (QI) Team HEDIS Focus Workgroup met regularly to review monthly performances of HEDIS measures; complete causal/barrier analysis; and monitor status updates of interventions developed specifically to improve HEDIS rates, including performance on measures in the Care for Chronic Condition domain. The following are improvement activities continued or implemented in 2013:

- To assist in ensuring that all service data were received from providers, 'Ohana developed a claims report card made available to FQHCs quarterly. The report card included top denials, information on how to correct, and total claims received by count for the quarter.
- For lab data, 'Ohana continued receiving lab results directly from lab vendors, Clinical Laboratories, and Diagnostic Laboratory Services. In addition, providers who performed blood tests in-house (i.e., not at a diagnostic laboratory) were identified through claims data. During the quality focused provider visits, QI staff discussed the importance of receiving lab results from the provider and retrieved appropriate medical records. These medical records were reviewed and data entered into an auditor-approved supplemental database.
- Quality-focused provider visits were conducted by the Quality Improvement (QI) staff and Provider Relations Representatives. QI performed the quality-focused visits for top volume providers (based upon panel size) and provider relations representatives performed the quality-focused visits for all other providers. During these quality-focused provider visits, 'Ohana staff provided education and coaching on HEDIS measures as well as resources to assist providers in improving HEDIS rates, including distribution of HEDIS toolkits and care gap reports. 'Ohana also provided information on its disease management (DM) program and instructions on how to refer a member to the program.
- Clinical Practice Guidelines (CPGs) were also reviewed during quality focused provider visits as HEDIS measures are often aligned with CPGs. Providers were informed that detailed

information on CPGs is available through the 'Ohana Web site. The QI staff identified providers not meeting CPG adherence (e.g., diabetes, obesity, and preventive care guidelines). Further education and coaching for these providers was performed by 'Ohana's medical director.

- In previous years, 'Ohana's vendor, Outcomes, was unable to retrieve 20 to 25 percent of the medical records during the HEDIS medical record retrieval season. In order to address this barrier, 'Ohana has insourced the process of scheduling and retrieving of medical records. 'Ohana onboarded 24 temporary staff to schedule and retrieve records, resulting in retrieving approximately 22 percent more records than Outcomes retrieved in the past. Retrieving more records afforded more opportunities to obtain hybrid HEDIS compliance information.
- 'Ohana developed and published chronic condition disease-specific articles for both member and provider newsletters.
- In addition to 'Ohana's ongoing disease management programs to educate members and periodicity letters to members to remind them of preventive screenings, several outreach programs to educate members on chronic condition management and preventive care were conducted by the QI staff and the Service Coordination department. The following lists the various outreach programs:
  - Centralized Telephonic Outreach program consisted of a QI Coordinator conducting calls to members with HEDIS care gaps and assisting with scheduling appointments with their physicians.
  - EPSDT coordinator outreached to pediatric members to educate and assist with scheduling appointments for well-visits and immunizations updates.
  - The service coordinators (SCs) performed outreach calls to members with diabetes and chlamydia care gaps. They educated members about the importance of diabetes management and chlamydia screenings and reminded or assisted with scheduling appointments with the members' physicians.
  - The service coordinators and case managers also accessed care gaps via EMMA (clinical electronic medical record for 'Ohana Health Plan) and addressed them with members when they completed annual health and functional stats assessments.
- 'Ohana recognizes that educating members about their diseases, setting disease-specific target goals, and improving members' self-management skills positively affects their health outcomes while increasing compliance with chronic conditions HEDIS measures. 'Ohana's Disease Management (DM) program has continued to put a premium focus on high member engagement during health coaching sessions and using member-driven goals to measure progress. The importance of preventive visits and timely tests/screenings in avoiding care gaps is addressed during each member contact. 'Ohana embedded within each DM program's teaching module key points that give periodic reminders on what tests/procedures are due, why they are important, and how often they should be completed. As needed, DM RNs have reached out to the treating providers to assist with scheduling of follow-up visits and have collaborated with service coordinators to ensure members' transportation barriers to medical appointments are resolved in a timely manner.
- During initial assessment and periodic reassessments, service coordinators educate members with chronic conditions about availability of the DM program. If members decline enrollment in DM, service coordinators offer to provide members with educational materials about their health condition(s) and the recommended tests/procedures needed.

- ‘Ohana has submitted a Preventive Care Checklist of HEDIS-related tests and procedures to the State and is awaiting approval for its use for members. The reader-friendly checklist doubles as an educational tool, explaining in simple layman’s terms the “why” behind the age-specific, gender-specific, and disease-specific tests and procedures on the list. The intent is for SCs/DM RNs to discuss the checklist with members and instruct them to bring the checklist to their doctor’s office during follow-up visit for completion.
- In review of the top diagnoses for ER visits/1000 in 2013, ‘Ohana observed that the majority of ER visits were related not to particular diseases, but to symptom management. In February 2014, ‘Ohana pulled (by diagnosis) the top 20 members overutilizing the ER. These members were discussed at ‘Ohana’s Hospital Utilization Review and Readmission Team (HURRT) meetings. It was noted that many of these members had been designated “unable to contact” when ‘Ohana was reaching out for case management upon enrollment. After intense review of these members’ claims, authorizations, and utilization patterns, ‘Ohana succeeded in contacting quite a few members through their behavioral health (BH) case workers and subsequently developed plans to educate them about going to their PCP or psychiatrist for some less urgent issues. ‘Ohana also educated members about the possibility of using the Nurse Advice Line and/or Urgent Care centers.
- Provider Relations contracted with two new urgent care centers in late 2013, and the service coordinators have been educating members about this avenue for urgent care type services.
- For those members still unable to be contacted and with no other outreach avenues despite intense review of their claims, authorizations, and documents, ‘Ohana highlighted the member as a “member alert” in its electronic system. If such a member is admitted or if the ER calls the health plan, ‘Ohana will assign a service coordinator to go to the facility to perform a health and functional assessment and provide education/training on alternatives to using the ER. In addition, the service coordination staff members receive a report of high ER utilizers at least quarterly in order to identify members who may need assistance with alternate services. As a result, ‘Ohana has observed decreases in ER utilization and readmission rates for those members presented to the HURRT.

UnitedHealthcare Community Plan

UHC CP's HEDIS Performance Measures Recommendations

- Although the health plan showed improvement in all CDC indicators from the previous year, seven of the 10 indicators were still below the MQD Quality Strategy target, and two of those measures benchmarked below the 25th percentile. Effort around this measure should continue.
- UHC CP should monitor data completeness specific to its Hawaii product to ensure that all data from providers are accurately and timely received.
- UHC CP should consider educating its members on their disease conditions and on overall health and wellness. This will help to ensure members are aware of services recommended to treat their conditions and maintain good health. Provider education may be necessary on practice guidelines and standards of care for different disease states.
- UHC CP reported a high *ED Visits* rate and benchmarked below the national HEDIS 2012 Medicaid 50th percentile. For this measure, a lower rate indicates better performance. While it is recognized that the QExA health plans may enroll sicker individuals with more chronic conditions than the QUEST health plans enroll, UHC CP should review the top diagnoses for these visits and determine if additional disease management programs or other system interventions could be implemented to decrease any inappropriate use of the ED.

Improvement Activities Implemented:

As a result of member, provider, and health plan interventions, all but two *CDC* submeasures showed an increase in HEDIS 2014. *CDC LDL-screening* did not show an improvement and remained the same. The *CDC Medical Attention for Nephropathy* showed a decrease not statistically significant. Of the submeasures, all but three *CDC* submeasures reached the goal of improving over the 75th percentile. The three submeasures still below the 75th percentile are *Blood Pressure <140/80* (to be retired in HEDIS 2015), *Blood Pressure <140/90* (to be moved to *Controlling Blood Pressure* measure in HEDIS 2015) and *HbA1c Testing*. All three submeasures increased in HEDIS 2014 but remain below the 2013 NCQA 75th percentile. UHC CP will continue to work on improving the *CDC* measures, especially the submeasures below the 75th percentile.

- A Project Evaluation was completed for the UHC CP annual HEDIS measurement. Barriers to data completeness were identified specific to the Medical Record Review/Hybrid Measurement project. UHC CP's current process for medical record review was identified as being unable to fulfill quality requirements. UHC CP instituted a new process using resources and tools from OPTUM (a UnitedHealth Group company) for medical record reviews (MRR) and implemented more frequent and more effective oversight by the health plan during the HEDIS season. Quality department staff members were also added to assist with ongoing MRR data extraction and measurement on an interim basis and to work with the provider network resolving issues with medical record extraction from provider offices. These interventions were implemented in the fall and winter 2013. The health plan will continue to evaluate and resolve barriers to the MRR/Hybrid Measurement project. The health plan also monitors administrative data completeness through assessments of claims processing quarterly.

- Members with chronic conditions such as congestive heart failure, diabetes, obesity, asthma, and high risk pregnancy are identified and are enrolled in UHC CP's Disease Management Program. Members enrolled in specific disease management programs are regularly sent pertinent materials. Disease management articles were released in 2013 and 2014 through the UHC CP Member HealthTalk newsletter. Providers were educated on HEDIS requirements and clinical practice guidelines semi-annually. Clinical Practice Guidelines are also made available on the plan Web site (www.uhccommunityplan.com) and in the provider newsletter and the Provider Administrative Guide. UHC CP organized and held the Hawaii Quality Conference in February 2014 where primary care providers were educated on HEDIS and important updates. UHC CP also provided information on the health plan's available support services to providers. Providers with high levels of gaps in care were and continue to be visited to explain HEDIS requirements and were provided member level gaps in care reports. UHC CP also implemented the Accountable Care Communities program to engage providers and share data such as gaps in care with high volume providers more effectively.
- Members with diabetes are identified and enrolled in the UHC CP's Disease Management Program. Disease management members are regularly sent materials on diabetes disease management and PCPs were sent letters informing them of their patients' enrollment into the program. Articles on heart, retinal, and lung complications due to diabetes were released in 2013 and 2014 through the UHC CP Member HealthTalk newsletter.
- Clinical practice consultants were added to the Quality Staff to focus on provider quality performance interventions. Provider network advocates were also added to improve assistance and training of providers. Quality team members were added to focus on quality performance improvement. A focused intervention on the CDC measure was implemented by the Quality Team in coordination with the Service Coordinator Team to encourage members to get CDC services in fall 2013. Trainings were provided to service coordinators to address HEDIS gaps in care. Trainings on motivational interviewing were also provided to service coordinators to address difficulties in improving motivation for disease self-management among members. Training on quality performance measures were provided to all staff to promote quality within the organization culture.

2013 Validation of Performance Improvement Projects

AlohaCare

AlohaCare's Performance Improvement Projects Recommendations

- AlohaCare should conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of its most recent data. The health plan must accurately document the analysis, providing the data, identified barriers, and the rationale for how barriers are prioritized.
- For each intervention implemented, AlohaCare should have a process in place to evaluate the efficacy of the intervention to determine if it is having the desired effect. The results of each intervention's evaluation for each remeasurement period should be included in the PIP documentation. If the interventions are not having the desired effect, AlohaCare should discuss how it will address these deficiencies and what changes will be made to its improvement strategies. AlohaCare should ensure that the interventions implemented for a specific barrier are truly relevant to that barrier and will directly affect study indicator outcomes.
- AlohaCare should determine if current interventions should be modified or discontinued or if new interventions should be implemented to improve results.
- AlohaCare should conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if a subgroup within the population has a disproportionately lower rate that negatively affected the overall rate.
- AlohaCare should standardize successful interventions systemwide and continuously monitor interventions to ensure their ongoing success.
- AlohaCare should reference the PIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed.

Improvement Activities Implemented:

- AlohaCare implemented two new performance improvement projects (PIPs) in CY 2013: *Plan All Cause Readmissions* and *Diabetes Mellitus*. For each of these projects, AlohaCare implemented a cross-departmental PIP work group. Each workgroup participated in conducting the initial barrier analysis, developing the intervention strategy, and monitoring the implementation and effectiveness of the plan.
- With the completion of the first remeasurement in June, the workgroups are now engaged in the "Study" step of the Plan-Do-Study-Act (PDSA) cycle. They are reviewing data, determining which further drill-down analyses will be useful, reviewing data on implementation of the interventions, and will be planning which interventions should be continued and which additional interventions should be implemented to reach the improvement goals for each project.

HMSA

HMSA's Performance Improvement Projects Recommendations

- HMSA should conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of its most recent data. The health plan must accurately document the analysis, providing the data, identified barriers, and rationale for how barriers are prioritized.
- For each intervention implemented, HMSA should have a process in place to evaluate the efficacy of the intervention to determine if it is having the desired effect. The results of each intervention's evaluation for each remeasurement period should be included in the PIP. If the interventions are not having the desired effect, HMSA should discuss how it will address these deficiencies and what changes will be made to its improvement strategies. Without an evaluation plan, the health plan cannot determine whether to modify or discontinue existing interventions, or implement new strategies, thereby reducing the likelihood of achieving the desired goals and improving performance.
- HMSA should ensure that the interventions implemented for a specific barrier are truly relevant to that barrier and will directly affect study indicator outcomes.
- HMSA should determine if current interventions should be modified or discontinued or if new interventions should be implemented to improve results.
- HMSA should conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if a subgroup within the population has a disproportionately lower rate that negatively affected the overall rate.
- HMSA should standardize successful interventions systemwide and continuously monitor interventions to ensure their ongoing success.
- HMSA should reference the PIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed.

Improvement Activities Implemented:

- HMSA conducts causal/barrier analysis and evaluation of the efficacy of its interventions regularly, including, at minimum, at the beginning of each year for the preceding year for its annual evaluation. Many programs are evaluated more frequently than annually.
- HMSA follows continuous quality improvement practices of PDSA in the development and implementation of strategies. For its PIPs, additional causal analysis and subgroup drill-down are conducted as preparation for review of the PIP. At that time, barriers are reviewed and prioritized in light of interventions and overall strategy and new interventions are added either then or at other times during the year as the need presents.
- HMSA updates interventions in response to identified barriers. For example, in the *Keiki Care* PIP, HMSA added a new intervention aimed at the higher age group after evaluating the effectiveness of the past intervention. In the *Diabetes Care* PIP, HMSA changed its Pay for Quality measures and updated its reimbursement rate for diabetes education, based on an evaluation of specific HEDIS measure performance.

- HMSA regularly conducts drill-down analyses during the review of interventions. For example, in the *Diabetes* PIP HMSA analyzed comorbidities as a condition that may influence better control of HbA1c and found that members with diabetes and mental conditions had poorer control of their HbA1c. The intervention was adjusted to include coordination between medical and behavioral health.
- Many of HMSA's programs are standardized, particularly programs such as Pay-For-Quality and Patient-Centered Medical Home. Provider compensation is tied to such programs, making a high level of standardization necessary.
- In HMSA's model, the health plan serves as a catalyst for change within the patient-provider relationship. Standardized approaches such as aligning the provider incentive program with the plan's clinical quality goals, encouraging care models such as the Patient-Centered Medical Home, and making tools such as Cozeva available to providers are the framework around which change can occur. This approach aligns with Med-QUEST's value-based purchasing model outlined in the RFP.
- HMSA encourages flexibility and creativity at the provider level to address specific clinical and population needs. An example is the Advanced Hospital Care (AHC) program. The AHC incentivizes providers to lower admission rates while providing information about readmissions and other indicators. Through this program, hospitals have adopted a discharge champion team approach and regularly review cases to identify patterns and barriers regarding readmissions.
- Specific to the Advanced Hospital Care program, HMSA sponsors collaboratives both in Hawaii (2013) and at Premier's national conference (2014). For diabetes and keiki care (as well as other clinical needs), HMSA works with provider organizations to hold regular collaborative meetings to share best practices in clinical care and service.

Kaiser

Kaiser's Performance Improvement Projects Recommendations

- When submitting its PIPs, Kaiser must include all applicable specifications and attachments referenced in its PIP documentation.
- Kaiser should conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of its most recent data. The health plan must accurately document the analysis, providing the data, identified barriers, and rationale for how barriers are prioritized.
- For each intervention implemented, Kaiser should have a process in place to evaluate the efficacy of the intervention to determine if it is having the desired effect. The results of each intervention's evaluation for each remeasurement period should be included in the PIP. If the interventions are not having the desired effect, Kaiser should discuss how it will address these deficiencies and what changes will be made to its improvement strategies. Kaiser should ensure that the interventions implemented for a specific barrier are truly relevant to that barrier and will directly affect study indicator outcomes.
- Kaiser should determine if current interventions should be modified or discontinued or if new interventions should be implemented to improve results.
- Kaiser should standardize successful interventions systemwide and continuously monitor interventions to ensure their ongoing success.
- Kaiser should reference the PIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed.

Improvement Activities Implemented:

Kaiser reviewed the current interventions and, due to the change in cholesterol treatment guidelines and the fact that HEDIS will no longer be measuring it this year, determined that its *Diabetes* PIP will need to be retired or the indicator changed.

'Ohana

'Ohana's Performance Improvement Projects Recommendations

- 'Ohana QUEST should include the State-modified technical specification as referenced or document the visit type codes used to identify the data elements being collected.
- 'Ohana QUEST should ensure it corrects the data categories documented in Activity III so they align with those specified in the State-modified technical specification.
- 'Ohana should conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of its most recent data. The health plan must accurately document the analysis, providing the data, identified barriers, and rationale for how barriers are prioritized.
- For each intervention implemented, 'Ohana should have a process in place to evaluate the efficacy of the intervention to determine if it is having the desired effect. The results of each intervention's evaluation for each remeasurement period should be included in the PIP. If the interventions are not having the desired effect, 'Ohana should discuss how it will address these deficiencies and what changes will be made to its improvement strategies.
- 'Ohana should ensure that the interventions implemented for a specific barrier are truly relevant to that barrier and will directly affect study indicator outcomes.
- 'Ohana should investigate the reasons for any decline in performance and, based on the findings, implement strategies to improve performance.
- 'Ohana should determine if current interventions should be modified or discontinued or if new interventions should be implemented to improve results.
- 'Ohana should conduct a "drill-down" type of analysis before and after the implementation of any intervention to determine if a subgroup within the population has a disproportionately lower rate that negatively affected the overall rate.
- 'Ohana should standardize successful interventions systemwide and continuously monitor interventions to ensure their ongoing success.
- 'Ohana should reference the PIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed.

Improvement Activities Implemented:

'Ohana revised its PIP to reflect State-modified technical specifications. The PIP Completion Instructions were used to ensure all documentation requirements for each activity were addressed.

- Causal/barrier analysis was completed in the Quality Improvement Intervention Workgroup (QIIW) and Quality Improvement (QI) Team HEDIS Focus Workgroup. The QIIW consisted of internal staff from different functional departments (i.e., Service Coordination, Provider Relations, Operations, Customer Service [CS], and Utilization Management, etc.). The QI HEDIS Focus workgroup consisted of only QI staff members. These workgroups met regularly to discuss barriers, implement and monitor interventions, and analyze data. Interventions implemented were tied to barriers identified to ensure direct impact on study indicators. A fishbone diagram of barriers was utilized for each PIP and barriers were prioritized into four main issues (which became known as the fundamentals to improve in preventive health care):

Getting the Member to the Doctor, Getting the Doctor to Do the Right Service, Getting the Encounter Report, and Data Management. These fundamentals were the focus when brainstorming and planning new interventions. Smaller measure specific workgroups, related to specific study indicators, were created to evaluate existing interventions and plan new interventions, as needed. Each workgroup utilized action plans to track and monitor progress of interventions and created appropriate data collection tools. Analysis of interventions was completed 2–4 weeks after implementation of a new intervention and every 3–6 months ongoing. Analysis included reviewing strategy effectiveness, revisions needed for data collection tools, considering challenges and barriers, and trending of monthly HEDIS rates. The workgroups also reviewed monthly HEDIS rates to evaluate in effectiveness of interventions.

- Drill-down analysis of diabetic care gaps by city, gender, age, ethnicity/race, and PCP was completed in 2013 and compared to 2012. The analysis was mostly helpful in identifying the age group and cities on which to focus interventions. The top 10 providers with the most diabetic care gaps were mostly FQHCs; therefore, the QI staff focused on HEDIS measure education specific to diabetes during the quality-focused provider visits with these FQHCs.

UnitedHealthcare Community Plan

UHC CP's Performance Improvement Projects Recommendations

- UHC CP should ensure that the Study Indicator 1 title in the *Diabetes Care* PIP aligns with the HEDIS technical specification. The HEDIS technical specification definition for HbA1c Control Levels <8% states, "Identify the most recent HbA1C test during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0%...." The Study Indictor 1 title should reference the most recent HbA1c test.
- The health plan should ensure that the Study Indicator 2 statistical test results are updated to include numerator changes made to the *Diabetes Care* PIP baseline data.
- For any intervention implemented, UHC CP should have a process in place to evaluate the efficacy of the intervention to determine if it is having the desired effect. The results of each intervention's evaluation for each remeasurement period should be included in the PIP. If the interventions are not having the desired effect, UHC CP should discuss how it will address these deficiencies and what changes will be made to its improvement strategies.
- UHC CP should standardize successful interventions systemwide and continuously monitor interventions to ensure their ongoing success.
- UHC CP should reference the PIP Completion Instructions to ensure that all documentation requirements for each activity have been addressed.

Improvement Activities Implemented:

- The Study Indicator 1 title in the *Diabetes Care* PIP was clarified to indicate that the most recent HbA1c Test is referenced to ensure numerator compliance.
- Statistical test results comparing all period results to the baseline data were included in all PIP projects.
- The effectiveness of interventions and follow-up interventions to address further issues were discussed in all PIP projects. The health plan is incorporating tracking in all interventions implemented to enable a more accurate measurement of effectiveness.
- Successful interventions that have been standardized are indicated as ongoing interventions.
- The PIP studies were updated to ensure that all documentation requirements referenced in the PIP completion instructions have been addressed.

2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child 5.0H Survey

AlohaCare

AlohaCare's CAHPS Child Survey Recommendations

Based on an evaluation of AlohaCare's results, the priority areas identified were *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Improvement Activities Implemented:

With the guidance of the Service Excellence Committee and its subcommittees, AlohaCare implemented the following:

- A cultural competency improvement initiative for the organization with an initial focus on capturing member spoken and written language preferences and developing strategies to assure that members receive communications that respect their preferences.
- Revision of AlohaCare's external Web site to allow for enhanced capabilities related to provider searches. Members can search for a provider by island, location, specialty, and gender.
- A 24/7 Nurse Call Line.
- In response to a specific analysis of CAHPS results, warm transfers of all medication-related calls from Customer Service to pharmacy staff to assure that members calling with questions about medications receive prompt and accurate information.

With the guidance of the Service Excellence Committee and its subcommittees, AlohaCare continued the following:

- Work with community health centers implementing a Patient-Centered Health Care Home to incorporate design features that improve patient access, including assigning patients to a designated primary care team, developing open access scheduling, and redefining care team member roles to free up appointment access and accommodate same day services. Six of these health centers have now received PCMH recognition from NCQA.
- The access and availability grant program, providing $300,000 in grants in the last fiscal year to neighbor island providers to recruit new primary care and behavioral health practitioners to their communities.
- Training for customer service staff focusing on the goal of first-call resolution.

HMSA

HMSA's CAHPS Child Survey Recommendations

Based on an evaluation of HMSA's results, the priority areas identified were *Rating of Specialist Seen Most Often*, *Customer Service*, and *Getting Care Quickly*.

Improvement Activities Implemented:

- As part of its strategy to improve CAHPS, HMSA supports and promotes activities that build the provider-patient relationship and the importance of members' engagement in their care, which can lead to better satisfaction and access to care.

Activity	Description	Status
Patient-Centered Medical Home (PCMH)	The PCP, working with the member, helps direct and drive the care of the member. HMSA strongly encourages members to develop a relationship with one provider, which helps with access to care and care coordination.	Ongoing
Cozeva	This program provides PCPs and members another way to communicate and track checkups and screenings.	Ongoing
Educational / Informative Article: *CVS Caremark introduces MinuteClinic*	This article provides members with information about walk-in medical clinics available in selected Longs Drugs, offering members alternative access to care.	Completed HMSA's member newsletter, Island Scene, Winter 2014, pages 42–43.
Educational / Informative Article: *Work With Your Doctor*	This article promotes the importance of the PCP-patient relationship, member involvement in care, preparing for and making the most of a visit with the PCP.	Completed Island Scene, Winter 2014, page 57.
Educational / Informative Article: *Helping You Make Wise Choices*	This article encourages patients to take an active role in their health care and provides a checklist to help members prepare for and make the most of visits with their provider.	Completed Island Scene, Spring 2014, pages 18–20.
Educational / Informative Article: *The Snowball Effect*	This article talks about two quality programs, Patient-Centered Medical Home (PCMH) and primary care Pay-For Quality, which support improved quality care.	Completed Island Scene, Summer 2014, page 43.

Activity	Description	Status
Educational / Informative Article: *A Regular Dose of Care*	The article uses the experience of one member to highlight the importance of having a primary care provider and establishing a relationship with a provider.	Completed Island Scene, Summer 2014, pages 40–41
Patient Reminder Cards *Asking Questions Keeps You Healthy*	Patient reminder cards help members prepare for and make the most of a visit with their provider. This checklist was in the Spring 2014 Island Scene and offered in some provider offices.	Ongoing
QUEST Member Newsletter	Tips were provided to members about obtaining care from a specialist or PCP, scheduling appointments, and preparing for the visit.	Completed — June 2014
QUEST Timely Access Surveys	Access to care is monitored through surveys to measure appointment availability. Surveys are conducted quarterly, alternating between members and providers.	Ongoing
OmniTrak Provider Survey	To support its effort to promote the importance of having a primary care provider by providing current provider status, HMSA contracted with OmniTrak to contact HMSA providers to ask whether they were accepting new patients for the lines of business in which they participate.	Completed (January 2014–March 2014)

Kaiser

Kaiser's CAHPS Child Survey Recommendations

Based on an evaluation of Kaiser's results, the priority areas identified were *Getting Care Quickly*, *Getting Needed Care*, and *Rating of Specialist Seen Most Often*.

Improvement Activities Implemented:

- No-show appointment follow-up process has been in place in Kaiser's clinics for years, but the plan reported it has not been consistently followed. In addition, an identical process was being followed by Kaiser QUEST case management staff. In 2013, meetings were held to reinforce the clinics' responsibility for following up on no-shows. This freed the QUEST case management staff to focus on high risk no-show patients and other strategies to facilitate a member's appointment compliance, including but not limited to checking for future appointments with different providers, meeting the member at the appointment, and conducting home visits.
- "Max-packing" is one of several strategies which Kaiser's QUEST case managers are encouraged to use especially for noncompliant patients or those with transportation needs. Kaiser is able to consolidate appointments around members' transportation availability (i.e., when they have someone who can drive them) and is conducive to meeting with the member face to face while they are at one location for multiple appointments.
- Kaiser members have access to online tools that make communication with their providers easy and convenient. Communication tools include e-mail and the ability to check test results, make appointments, etc. In 2013, the Kaiser QUEST case management staff focused efforts on reinforcing access to these tools when communicating with members.

'Ohana

'Ohana's CAHPS Child Survey Recommendations

Based on an evaluation of 'Ohana QUEST's results, the priority areas identified were *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, How Well Doctors Communicate,* and *Customer Service.* Based on an evaluation of 'Ohana QExA's results, the priority areas identified were *Rating of Health Plan, Rating of All Health Care,* and *Customer Service*.

Improvement Activities Implemented:

- In an effort to expand access, 'Ohana explored alternatives to traditional one-on-one visits, through use of telemedicine in behavioral health (BH), particularly for the neighbor islands. 'Ohana began conducting claims testing with one of its BH providers.
- 'Ohana reported it considers the provider network part of its microsystem. The Utilization Medical Advisory Committee (UMAC) engages in 'Ohana's processes with physician attendance and reviewing and monitoring of processes and data, making recommendations as needed. The plan has an Office Advisory Group consisting of the providers' office staff, which is also being engaged in the plan's processes. System enhancements are conducted frequently to remain current with the latest technologies. Those systems assist in completing, tracking, monitoring, and trending reports.
- 'Ohana reported that quality remained one of the organization's top goals, and claimed it crucial to have engagement organizationwide of all staff members of every level. For this reason, 'Ohana continues to have an active Quality Improvement Intervention Workgroup (QIIW) comprised of staff members from all levels and every department to take a collaborative approach to improving quality health care for members as measured through HEDIS rates and CAHPS scores. Interventions developed from this workgroup often affect multiple departments, engaging staff of all levels. The QI team, in collaboration with the medical directors, continually evaluates ways to improve HEDIS and CAHPS interventions presenting them to the QIIW.
- Every functional department's operations continued to align with improving quality with sound initiatives. From Disease Management to Health Services (SC/CM/UM) to Customer Service, Provider Relations, and Operations; all associates continued to be engaged in quality initiatives. Customer Service representatives continued to address care gaps with members, as appropriate, through a unique system called CAREConnects when they called into the customer service phone lines. Customer Service representatives continued to receive soft skills training through team meetings to ensure that members are satisfied with the help received. Disease management RNs, service coordinators, and case managers continued to address care gaps with members and to assist to fulfill their needs, as appropriate.
- To continually increase awareness of the importance of member satisfaction, 'Ohana continued its CAHPS Associate Monthly Award program. Each month, associates were encouraged to nominate one another or themselves (because these associates often work independently) for actions which encompassed the core ways of increasing member satisfaction. Nominations were made under one of three categories: Employee Empowerment (share proven tips to help other associates with rendering excellent service to our members), Service Recovery (promotion of

member satisfaction), and Shared Decision Making (counsel members to feel empowered to discuss their health with providers and share in decision making). 'Ohana reported that this program has helped to keep focus on increasing member satisfaction and associates often feel grateful for the recognition when they read what another associate wrote about them in their nomination.

- In addition to quality training that is a part of every new hire's onboarding training, 'Ohana's Quality Improvement Team continually conducts quality-focused in-service training sessions for all departments. In these trainings, 'Ohana stresses the importance of quality, provides HEDIS and CAHPS metrics education, and discusses how each functional area affects and contributes to quality improvement.
- Access to care is monitored through telephonic timely access surveys conducted quarterly—surveying both members and providers interchangeably. Provider relations representatives educate providers on accessibility of timely appointments required by Med-QUEST and NCQA during provider orientation and ongoing education sessions. Providers not meeting requirements may be expected to produce a corrective action plan.

  'Ohana also offered as part of the PCMH program an incentive to include a stipend to providers who were open panel and willing to accept new 'Ohana members.
- Member grievances related to appointment availability or access to care are monitored real time for investigatory purposes and trended quarterly to identify providers receiving multiple complaints regarding access.
- Customer Service assists members in locating and securing providers when needed. This process is tracked and used for future requests and shared with Provider Relations to pursue open panel discussions or pursue contracting. As part of the care gap process, Customer Service agents, through three-way calls, assist members to schedule appointments with providers.
- 'Ohana's Community Advocacy staff provides 10 one-hour-long health presentations monthly throughout the State. Within these presentations, members may provide feedback about member experience (which is then brought to the appropriate department for follow up).
- In an effort to have and strengthen a formal means of communication with members, 'Ohana created a Members Matter Advisory Committee (MMAC). The QI team worked with Service Coordination, Case Management, Disease Management, Community Advocacy, and Customer Service to help recommend members who, based on past interactions/assessment, would be good resources for feedback about health care processes. 'Ohana reported that the members who participated were happy to know that the health plan staff wanted to hear firsthand from them about how to improve communications, services, interactions, etc. with members. 'Ohana received valuable feedback and continues to work on incorporating that feedback into its programs and processes.
- From the Health Services team, the disease management nurses have implemented a call to members a few weeks after they close the program to determine if members were satisfied with the program. For members in the Complex Case Management program, service coordinators also conduct a phone call once a member is discharged from the program to determine if the member was satisfied with services. In both cases, 'Ohana reported 85 to 95 percent satisfaction rates for the programs. Examples of areas for improvement noted were: the program is too long, maybe shorten it; I get too much mail; too many phone calls. 'Ohana continues to work towards improvement in these areas.

- Provider surveys are conducted twice a year to measure appointment availability. 'Ohana also conducts member surveys twice a year to gather member perception regarding wait time standards and experiences in getting in to see a provider. Providers are trained on members' rights and their responsibilities to adequately care for members. Provider wait times are also monitored and tracked through grievances. If a complaint is received, PR staff reaches out to the provider, investigates, educates, and provides feedback on findings.
- 'Ohana recognizes the value of direct patient feedback and plans to discuss the topic of comment cards in providers' offices with the Office Advisory Group. 'Ohana has found it helpful to have a forum to discuss ideas such as this in a formal format with provider office staff members. In one Office Advisory Group meeting, it was brought to 'Ohana's attention by a provider's office staff that sometimes members forget and do not know how to contact the plan or its vendors for services. To address this, 'Ohana has a "quick reference card" in development that includes all important phone numbers members would need: Customer Service; Transportation; Pharmacy; Nurse Advise Line; Community Case Management Corporation–Dental; Fraud, Waste and Abuse, etc.
- 'Ohana reports that it encourages providers to render the best care to its membership and to promote open communication including nonverbal communication such as ensuring eye contact and active listening. The plan has included articles in the provider newsletter regarding communication such as "Communicating Effectively for Coordination of Care" in the provider newsletter. 'Ohana's Community Advocacy staff provides 10 one-hour-long health presentations monthly throughout the State. A part of each presentation includes the necessity of feeling comfortable talking with one's provider. Service coordinators; case managers; and DM RNs often discuss this topic with members, encouraging them to be comfortable communicating with providers. When members call Customer Service, agents encourage members to provide consent to share information between the PCP and the specialist.
- The Health Services team piloted a project with select members to create a member personal health record to leave in the member's home. Information in the folder includes: member's direct contacts, emergency contacts, back-up plan, HEDIS care gaps, Preventive Care guidelines, how to contact their service coordinator, questions to ask your doctor at your next visit, etc. 'Ohana reported that members were very satisfied and really liked having all health information in one place. The SC updates the folder at each face-to-face visit and members have a place to put any 'Ohana information mailed to them so they can ask the SC questions upon their next visit. 'Ohana also includes "Did You Know" articles in member and provider newsletters outlining ways to encourage/participate in shared decision making.
- 'Ohana provides care gap reports to providers and care gap information is available to providers via the provider portal. Providers have been trained to utilize care gap reports to identify members overdue for services. In discussing the timing requirements of services, 'Ohana found that providers who utilize an EMR system have a built-in reminder system that alerts them when members are due for services. 'Ohana's member outreach uses the Centralized Telephonic Outreach program and includes care gap reminders on inbound calls to CS to remind members when they are due for services and to assist with appointment scheduling (three-way calls to provider), transportation, and interpretation services when needed.
- 'Ohana makes cultural competency information available to all providers and provider relations representatives discuss cultural competency during provider visits.

- In an effort to expand access, ‘Ohana explored alternatives to traditional one-on-one visits, through use of telemedicine in behavioral health, particularly in the neighbor islands. ‘Ohana began conducting claims testing with one of their BH providers.
- Providers are educated about member rights to choose a specialist as a PCP to encourage the right match of providers. Customer Service assists members through this process. Provider Relations also offers (during the recruitment process) an option to specialists to be credentialed as a PCP in addition to specialty care to expand PCP access to members.
- ‘Ohana continued to be an active partner in the “a hui for WE” (Wellness Events) movement, comprised of many local not-for-profit health advocacy groups that provide free interactive health workshops and on-site health screenings Statewide. The goal is to provide actionable information for individuals in an effort to motivate them to work and focus on better health. ‘Ohana continued its partnerships with the Women’s Health Center at The Queen’s Medical Center at which members received hands-on education regarding proper breast care and signs to look for in detecting lumps/bumps prior to completing their mammograms.
- HEDIS toolkits, which included a Personal Care Preventive Care Checklist for providers, were distributed by QI staff and PR representatives during quality-focused provider visits. Providers were encouraged to use this checklist to help them identify other screening, tests, vaccines, or assessments needed when a patient comes in for an office visit. The ‘Ohana online provider portal also offers care gap reports for providers’ use.
- Information about ‘Ohana’s referral process is in the provider manual and quick reference guides available at www.ohanahealthplan.com and distributed in-person or by mail. ‘Ohana does not require a referral from a member’s PCP for a member to be seen by a specialist; however, ‘Ohana reports understanding that it is a common managed care practice to provide a referral. Last year ‘Ohana implemented an Access to Care workgroup in which complaints and questions about access to specialists were discussed. Network, Provider Relations, Health Services, Customer Service, and Quality Improvement staff met to brainstorm on how to improve access, areas requiring additional specialists, and referrals to Provider Relations to outreach providers who were “open panel” but had members who reported being unable to get appointments. Customer service representatives assisted by helping members through the "Find a Provider" tool available via the ‘Ohana Web portal. If the member was unsuccessful through using the online tool, Customer Services, in partnership with Health Services and Provider Relations, assisted as part of the Access to Care project to seek out providers willing to accept the member. Service coordinators currently maintain a resource file that includes updated listings of providers and specialists in various geographical areas who have open panels and are accepting new patients. The resource file is continually updated, expanded, and shared through e-mail blasts among service coordinators. ‘Ohana’s EPSDT coordinator follows up on referrals documented on the EPSDT forms (8015 and 8016 forms) to ensure that pediatric members follow through on referrals made. In addition, ‘Ohana does not require a PCP to obtain authorization for a referral to an in-network specialist. This ensures that there are no delays with specialty referrals.
- ‘Ohana’s Health Services team piloted a project with select members to create a member personal health record to leave in the member’s home. Information in the folder includes member’s direct contacts, emergency contacts, back-up plan, HEDIS care gaps, preventive care guidelines, how to contact the service coordinator, “Questions to Ask Your Doctor at Your Next Visit,” etc. ‘Ohana reported that members were very satisfied and liked having all of their health

information in one place. The SC updates the folder at each face-to-face visit and members have a place to keep any 'Ohana information mailed to them.

In addition, 'Ohana sends periodicity letters to members. Letters are specific to gender, age, and chronic conditions and serve as a checklist for preventive visits and screenings or tests for which the member may be due. In addition to listing types of services needed, the health plan explains the reasons that these visits are important and outlines a list of things the member's physician may check for during the visit. This serves as a foundation to help members understand what to expect during the visit, thereby encouraging members to communicate with the physicians any questions, concerns, or expectations they may have regarding their health care and/or treatment options.

- All member materials, required to be at or below a 6th grade reading level, are monitored by 'Ohana's marketing department during creation to ensure that they are clear, concise and meet members' needs. The "WE" events is a forum to talk to members about understanding and relating to health materials. During 'Ohana's Members Matter Advisory Committee, members provided valuable feedback, including that pictures go a long way in helping them to understand materials. This is a suggestion the health plan will consider in developing new and updating existing materials.
- 'Ohana monitors call volume and has determined that call center hours are appropriate for the times and calls received and ensuring that calls are answered promptly. Currently, the phone system is also set up to ask members if they are interested in completing a survey, and all survey responses are reviewed for improvement opportunities.
- To ensure that customer service representatives are well equipped to address and take care of member concerns, each new representative undergoes four full weeks of new-hire training. Training includes everything from soft skills and effective communications skills to HIPAA, cultural competency, Medicaid, and Medicare. 'Ohana has invested in a dedicated trainer, and the plan extends training to offer nesting periods to ensure new hires are able to handle calls with confidence and quality. 'Ohana also conducts refresher trainings during team meetings to ensure that representatives are well aware of the resources available to assist them in providing excellent customer service to their members. Management from other departments often join Customer Service team meetings in order to provide insight into how the important work the customer service representatives do affects and directly contributes to the quality programs.
- Customer Service focuses on various metrics including Average Speed of Answer, Service Levels, Average Handling Time, Customer Satisfaction, First Call Resolution, and quality to measure the success of service and the ability to assist members. Customer Service performance measures are tracked monthly and evaluated to ensure that regulatory call center metrics are met. When metrics are not met, root cause analysis is conducted and corrective action is taken. The Customer Service performance measures are trended over the year and are included in the Quality Improvement Evaluation report. Copies of the report are distributed to the physicians on the Utilization Medical Advisory Board (which consists of external physicians).

UnitedHealthcare Community Plan

UHC CP's CAHPS Child Survey Recommendations

Based on an evaluation of UHC CP QUEST's results, the priority areas identified were *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Customer Service.* Based on an evaluation of UHC CP QExA's results, the priority areas identified were *Rating of Health Plan, Rating of All Health Care,* and *Customer Service.*

Improvement Activities Implemented:

- In 2013, UHC CP offered members the use of Teladoc services, which offered 24/7 access to a doctor via phone and online video consultations. In 2014, the health plan is working to upgrade the Teladoc service with the NowClinic, which is UHC CP's online care solution platform to connect members and providers. Teladoc services are relayed to members through NurseLine, UHC CP's 24-hour talk line, where members can connect to a registered nurse to discuss their health care needs. HouseCalls and In-Home Assessment Program (IHAP) are services available to qualified members of UHC CP's Medicare Advantage Dual Special Needs Plans, and also those dual eligibles in UHC CP's Medicaid QExA plan. Through this service, health care practitioners make in-home visits to members to assess health conditions. Through the in-home visits, the plan is able to evaluate members' current health care needs and make recommendations about how to maintain health and topics to discuss with their primary care physicians during their next visits.
- In 2014, UHC CP partnered with Home Outreach Program & E-health (H.O.P.E), a chronic disease management program that helps high-risk patients manage symptoms. The H.O.P.E program uses daily monitoring and feedback from telehealth nurses to reduce both emergency room visits and hospitalizations.
- In late 2013, UHC CP introduced its member/family-centric Clinical Effectiveness Initiative (CEI) Model. The CEI Model is based upon a fundamental whole-person approach across all points of service and the continuum of care. It aligns with the State's core principles of quality over quantity, personal accountability, wellness and prevention, engagement, and member choice to realize positive health outcomes and increased economic value of care.
- Based on an evaluation completed in 2013, UHC CP has insourced, as of June 1, 2014, member and provider services and support functions and has located the new call center in the current Honolulu office.
- UHC CP has changed its provider services model by offering direct servicing without going through a local vendor as was done in the past. The newly formed provider advocacy team has been trained to assist providers with educational needs, claims resolution, and contracting needs. This new model is designed to ensure that providers have access to the resources available to them and that claims are paid timely and accurately. Direct provider servicing will enhance providers' experiences as they will receive direct access to UHC CP provider services and will no longer go through a third party.
- A local quality committee structure exists within the health plan for discussion, review, and approval of all quality (clinical and nonclinical) initiatives within the organization.

Representation from all areas of the business exists within the quality structure. In addition, quality information is shared monthly at all-management meetings and quarterly at all-staff meetings. The QAPI document articulates the mission and goals of the organization and demonstrates the alignment of these at the national, regional, and local levels of the organization. Goals and expectations for performance are defined and evaluated annually in the Quality Program Evaluation. Quality Initiative training at all staff levels was conducted in the 3rd quarter of 2013. Gaps in member care were identified and shared with all service coordinators and Provider Network Team.

- Quarterly timely access surveys are conducted to determine provider compliance with appointment availability standards. Providers identified as noncompliant with the standards are provided direct education and feedback. Appointment standards are communicated regularly to providers via the Practice Matters provider newsletter and the Provider Administrative Guide.

  Quarterly PCP and specialty provider availability data are reported, reviewed, and analyzed to determine where gaps in the provider network may limit access to care. Interventions are developed and approved through the plan's Service Quality Improvement Committee (SQIC). Some barriers identified in 2013 were that providers were leaving the State for the mainland, retiring, or choosing not to participate with a State-funded program due to low reimbursement. In addition, the neighbor islands do not have the population base to support certain specialties or subspecialties which can result in providers limiting their panels. Based on feedback from internal and external staff as well as from some providers, workload and issues surrounding reimbursement continue to be one of the biggest barriers to providers opening and/or reopening their panels to new members.
- In 2013, the Member Advisory Group (MAG), chaired by the Customer Services director, was created. This committee reports to the SQIC and advises on issues concerning the overall member experience, including service delivery, quality of covered services, network issues, provider performance, member rights and responsibilities, and the member grievance and appeal process. The MAG may also provide information to the Quality Management Committee. The MAG is a representative cross section of UHC CP's member population. The MAG membership includes:
  - Hawaii Customer Services director
  - Hawaii executive leadership team representative
  - Community representatives (including patients and family members)
  - Advocacy groups (planned)
  - Community-based providers reflective of the member demographics (planned)
- To facilitate better access, UHC CP has implemented its Patient-Centered Medical Home model focusing on open access. This includes reviewing scheduling patterns from providers and recommending an attempt to shift to an open access scheduling model. The open access scheduling model allows for blocks of time that are free for same day appointments and walk-ins, helping minimize wait times for scheduled members. UHC CP recommended that providers conduct pre-visit planning to ensure that members have adequate time for their needs. For example, during a pre-visit planning session, a member identified as requiring an EPSDT visit would be scheduled for a 30–45 minute time slot. This allows for a thorough visit with time to administer immunizations and perform diagnostic tests.

- In 2013, UHC CP conducted bi-annual provider education and training sessions and ad hoc sessions when identified through grievance and appeal reports and feedback from UHC CP staff and external partners. Education included information about cultural competency and member rights and responsibilities to help providers understand the cultural differences and how they can partner with the member to better understand the best method of communication to ensure a successful partnership and quality of care.
  - During the provider training and education sessions, providers are given information on how to obtain a free copy of UHC CP's cultural competency plan. Continuing Education Unit (CEU) opportunities are also available to qualified health care professionals who take the online cultural competency course offered by UHC CP. Information about cultural competency is also available to providers in the Provider Administrative Guide and via the plan's online portal.
  - During provider education and training sessions, providers are given a quick reference guide about members' rights and responsibilities. This serves as a reminder to ensure that members' rights are taken into account when services are provided.
  - UHC CP also published newsletters for providers throughout the year that included information to encourage providers to partner with the member and their families to ensure quality care.
- In 2013, UHC CP shared "Family-Centered Care Self-Assessment Tool" to providers through its newsletter. The tool was designed to:
  - Increase outpatient health care providers' and families' awareness about the implementation of family-centered care, and
  - Provide an organized way for health care providers' to assess current areas of strength and identify areas for growth, plan future efforts, and track progress.
- All members are screened through the service coordination process. This includes a comprehensive assessment of the member's condition and the development and implementation of a care plan which includes monitoring, follow up, outreach, and engagement of the PCP as needed. UHC CP assists members who need help navigating the system to facilitate appropriate delivery of care and services.
- In 2013, gaps in member care were identified at the provider level and were communicated directly to the high-volume providers. Providers were given tools to support them in closing the gaps.
- A Patient-Centered Medical Home model, which is the basis of the UHC CP Accountable Care Community (ACC) Program, continues to be implemented in 2014 with specific FQHCs. A data analyst and a care advocate work specifically with the FQHC to provide data on care opportunities for their members and to assist with coordination of care of the identified care opportunities. The model is designed to include care coordination, quality, and access improvements across the spectrum of care and services.
- In 2013, UHC CP participated in and sponsored several community events promoting health education, health literacy, and preventive health care. UHC CP also distributed member newsletters with topics including preventive health, health education, health literacy, etc. Free workshops are also offered to members across all of the islands (Kauai, Maui, Oahu, and Hawaii). Topics include:
  - Caring for Diabetes

  - Taking Care of Your Heart
  - Healthy Weight, Healthy Life
  - Preventive Health Care and Screenings
  - All About Your UnitedHealthcare Community Plan
  - Is a Disease Management Program Right for You?
- The "Max-Packing" concept and its barriers were discussed in Quality Committee meetings. Barriers identified included that PCPs were not scheduling enough time for preventive services. Member level gaps in care reports are being generated to provide a checklist for providers to anticipate the patient's future medical needs.
- Network PCPs do not have to ask UHC CP for permission to refer a member to a network specialist or provider. A PCP may simply call and/or fax a referral directly to the network specialist or provider for services. Members may self-refer for women's health and family planning services.
- PCPs may utilize UHC's online secure portal to request prior authorization for referrals to out-of-network specialists/providers. These requests are reviewed and responded to within the time frame allowed by the MQD. Providers are encouraged to call in "URGENT" requests to ensure timely review and response.
- The referral and prior authorization process is communicated to providers via the bi-annual provider education and training sessions and as identified through feedback from grievance and appeal reports, Customer Service, Provider Services, Medicare Sales team, and external partners. During the education sessions, providers are provided with a Notification/Prior Authorization Quick Reference Guide to help them quickly identify services that require either a notification and/or a prior authorization. The referral and prior authorization process is also communicated through the provider newsletters, Provider Administrative Guide, and other forms of communication.
- UHC CP's 2013 Member Handbook includes a description of both the referral process and prior authorization process. As identified, members are also educated and/or reminded of the referral and prior authorization process.
- Analysis of contributing factors is limited to the review of grievances and appeals reports and feedback from internal staff and external partners. Some contributing factors to no-show appointments include but are not limited to the following:
  - Members do not fully understand the affect that a "no show" has on a provider's appointment schedule.
  - Transportation issues exist due to the traffic situation on Oahu.
- UHC CP's Member Handbook includes information on how to obtain transportation services. For referrals, coordinators follow up with members and remind them of appointments in an effort to decrease no-shows. Service coordinators also educate and/or remind members of the need for them to keep scheduled appointments. Service coordinators partner with members to identify barriers and opportunities in hopes of creating solution to ensure that members comply by providing the doctor's office with advance cancellation notice and/or rescheduling their appointments.
- Accountable Care Community (ACC) supports the open access scheduling model. Under the ACC, the health plan encourages providers to transition to an open access scheduling.

- One foundation of UHC CP's ACC program is the Patient-Centered Medical Home Model. The PCMH model focuses on improving access to care. This is accomplished through reviewing scheduling patterns from providers and recommending an attempt to shift to an open access scheduling model. The open access scheduling model allows for blocks of time available for same-day appointments and walk-ins. This helps minimize wait times for those members that are scheduled.
- A clinical quality analyst with an industrial engineering background and experience in time study analysis was hired to explore patient flow analysis. She has experience in time study analysis, which includes the design and requirements of the time study, simulation, and analysis of the results.
- In the Winter 2013 Member Newsletter, UHC CP provided detailed education to members about how to prepare for doctors. For example, "Think about what you want to get out of the visit before you go. Try to focus on the top three things that you need help with."
- In addition, UHC CP's Disease Management Program provides members materials specific to their condition.
- In 2013, UHC CP translated Hawaii 5-2-1-0 information (related to Hawaii's campaign to promote healthy lifestyles and prevent childhood obesity) into other languages such as Ilocano, Korean, Chinese, and Vietnamese in an effort to improve patient health literacy. UHC CP also translates the member handbook in other languages (Ilocano, Korean, Chinese, Tagalog, and Vietnamese).
- In 2014, UHC CP began developing disease-specific materials for service coordinators and eventually for members to aid understanding of health information being presented. Training on the use of the additional materials will be conducted for all service coordinators.
- Based on an evaluation completed in 2013, UHC CP has insourced member and provider functions and located the new call center in its current Honolulu office. UHC CP maintains a toll-free telephone number accessible to members from all islands. The call center is fully staffed between the hours of 7:45 a.m. to 4:30 p.m. (HST), Monday through Friday, excluding State holidays. When calling the toll-free customer service number, members will continue to receive the option to connect to a 24-hour NurseLine. After hours, callers may either leave a message or be connected to the 24-hour NurseLine. If the caller opts to leave a message, UHC CP will return the call the following business day. The plan is also offering an expanded NurseLine service called Live Nurse Chat. Live Nurse Chat is a confidential, real-time, one-on-one, Web-based chat service available 24 hours a day, seven days a week. The primary goal of Live Nurse Chat is to answer members' questions by providing general health information. Web-based pages with evidence-based clinical education information are sent to members during the chat. Members who present with symptoms are referred to a nurse for live telephonic triage. UHC CP continues to monitor and evaluate how well the new call center is meeting members' needs.
- UHC CP reports its training for the current QExA and QUEST programs is extensive and ongoing. When the plan insourced its call center functions, it revised its training curriculum to make sure the member services team has the program knowledge, skills, and ability to serve and support members in a culturally sensitive manner. Training for new hires is an intensive 16-week process including classroom instruction and hands-on practice. Training is conducted by a dedicated member services trainer responsible for all aspects of new hire and ongoing training, including training when program changes occur.

- By regularly monitoring calls, UHC CP measures results against its quality standards as an ongoing process. UHC CP's robust quality assurance program allows it to monitor performance standards and record all member calls daily. Via Qfiniti, a system monitoring tool, supervisory and quality teams can listen to calls and view the representative's computer screen. The plan reviews a random sampling of calls to verify high-quality standards are met and then provides coaching or retraining to improve service delivery based upon the results. New staff members are monitored more frequently by supervisors to identify and correct issues. To verify quality and accuracy of call handling, UHC CP conducts a monthly "calibration" call that includes member and provider services management, supervisors, health plan staff, and the quality monitoring team. During this call, UHC CP supervisors listen to member calls, review documentation, and develop action plans to address training, process, or quality issues. Feedback from the calibration meetings is used for continual quality and accuracy improvement.

2013 Provider Survey

All QUEST and QExA health plans received the following recommendations as a result of the provider survey findings:

- Providers consistently expressed concerns about difficulties with specialty and behavioral health referrals. To assist in streamlining this process, the health plan could conduct an analysis to determine the frequency with which specialty categories and medical services requiring a referral or authorization receive approval. For those specialty categories with high approval rates, the health plan could explore the option of no longer requiring a referral or prior authorization in order to improve and have a more positive affect on providers' abilities to supply quality care.
- To address providers' concerns with timeliness and burden of authorization and referral processes, the health plan should consider providing technical assistance or education to providers regarding the automated authorization and referral systems available to them and how to access and use them.
- Based on providers' feedback, opportunities exist to ensure that the health plan has an adequate formulary and adequate access to non-formulary drugs. Health plans typically choose which drugs to include in the formulary.
- Providers' feedback indicated that opportunities exist for ensuring that health plan staff have the knowledge and expertise necessary to address providers' questions and concerns regarding health plan policies and procedures. Educational sessions could be provided to health plan staff to ensure the health plan's workforce is up to date and well informed about information regarding patient care and services.

AlohaCare

Improvement Activities Implemented:

- AlohaCare has made changes to prior authorization requirements to reduce the burden on providers. These changes are being implemented in 2014.
- Improved system capability to allow online submission and approval of prior authorizations is being implemented.
- In 2013 and 2014, AlohaCare's Provider Relations staff members have conducted semi-annual provider training sessions in person on all islands to improve provider understanding of requirements and to address provider issues and concerns.
- In 2013, AlohaCare began distributing to primary care providers monthly "report cards" showing their performance on selected HEDIS performance measures. Feedback from providers on these reports has been positive.
- AlohaCare has continued training focusing on the goal of first-call resolution for customer service staff members who field calls from providers.

HMSA

Improvement Activities Implemented:

- HMSA notified its network providers through the HMSA Provider Update, June 2014, of the change to the HMSA QUEST referral process. Effective June 1, primary care providers (PCPs) need no longer register patient referrals to most HMSA participating specialists. If the specialist participates with HMSA QUEST and practices on the patient's island of residence, then PCPs do not have to register the referral with HMSA QUEST, except for all off-island specialty care, plastic surgery, podiatric, rehabilitation, and dermatology services. All nonparticipating providers, including out-of-state providers, continue to require HMSA's preauthorization.
- Aerial, a health care management platform implemented in early 2013, helps monitor and track authorization requests from date of receipt to date of outcome decision. An online tool to accept/process authorizations is also available, and HMSA QUEST continues taking steps to review the tool to address providers' concerns in order to implement improvement, streamline processes, and make it more user-friendly. Internal file reviews are periodically conducted to ensure regulatory (NCQA and/or State) compliance and primarily to identify gaps or issues, such as timeliness. If any are identified, education and/or corrective action are immediately addressed. HMSA provider services representatives and/or HMSA's medical management staff are available to assist providers related to authorization and referral systems.
- As a Medicaid program, the QUEST formulary is a closed formulary, consisting primarily of generic drugs and brand drugs in classes where no generic alternative exists. HMSA's Pharmacy and Therapeutics (P&T) Advisory Committee regularly reviews the formulary to ensure medically appropriate and cost-effective drugs are accessible. In addition, certain system edits are in place to check to ensure that members are using their medications safely and that drugs are monitored for effectiveness.
- HMSA providers serving patients who cannot use a drug on the formulary (or any alternative drugs on the formulary) are instructed to contact CVS to request a drug exception for the drug to be covered or may discuss such with a clinical pharmacist.
- HMSA QUEST servicing staff members are provided a 6–8 week training session upon hire. The provider handbook/e-library, member handbook, internal adjudication manual, and medical policies are documents and resources provided during training. Revisions and/or updates to any of these documents are communicated during weekly staff meetings and/or via HMSA's internal outreach communication e-mails. Refresher training is ongoing and/or provided based on provider- and member-specific issues and trends, or high volume inquiries. Staff members are also provided with one-on-one coaching to ensure servicing/knowledge consistency and competency.

Kaiser

Improvement Activities Implemented:

- Kaiser allows members to self-refer for many specialties, including behavioral health. An evaluation of the self-referral list was conducted to determine if it needs to be modified. In 2013, another service was added to the list to allow members direct access to additional specialists. Kaiser now has 16 specialty areas where members may self-refer.
- As a result of close collaboration between the health plan and its clinical partners, Kaiser was able to identify areas of opportunity that could be streamlined to remove unnecessary burden to the provider and to improve timely access to care and service for the member. An example is the change to the prior approval process to cover diabetic supplies for pregnant women with impaired glucose tolerance. Kaiser modified the process by changing diabetic supplies to automatic coverage with built-in "rules" applied by pharmacy, which made the entire process invisible to the provider. Instead of prior authorization for all, it is now automatic coverage with checks and balances by pharmacy before dispensing.

'Ohana

Improvement Activities Implemented:

- 'Ohana removed the prior authorization requirement for initial services for physical and occupational therapies as of August 1, 2013. The plan's prior authorizations (PA) data had suggested that these services are authorized whenever requested, so a decision was made to remove the initial PA requirement. Authorization is still required for continued services, because these services have high potential for overuse and misuse. 'Ohana is exploring other services to lift the PA requirements, including wound care procedures at the wound care clinic.
- Formal referrals are not a requirement for claims payment; however, providers are educated that they must complete and keep a referral on file.
- 'Ohana created and implemented a tool—Clinical Guidelines for Authorization—in collaboration with some providers selected to participate in the Office Advisory Group.
- 'Ohana also initiated a fax campaign to remind providers of the ability to submit and check status of PAs online. 'Ohana UM has partnered with the Provider Services Team during provider inservices both to review PA guidelines and processes and to participate in training for online PA submissions. 'Ohana generated a report to track the number of PAs submitted online to determine provider usage of tools.
- 'Ohana's Pharmacy and Therapeutics (P&T) Committee continued to meet six times per year to continually evaluate the formulary. The committee includes internal and external physicians and pharmacists as well as specialists. All drug classes are reviewed annually and new drugs/new indications are reviewed within 90–180 days of coming to market. If it is decided not to add a medication, providers may always request the medication via the Drug Evaluation Review process.
- Each 'Ohana department continued to hold regular team meetings in which training about health plan processes was conducted.

UHC CP

Improvement Activities Implemented:

- Network PCPs need not ask UHC CP for permission to refer a member to a network specialist/provider. PCPs may simply call and/or fax a referral directly to the network specialist or provider for services. Members may self-refer for women's health and family planning services.
- PCPs may utilize UHC's online secure portal to request prior authorization for referrals to out-of-network specialists/providers. These requests are reviewed and responded to within the time frame allowed by the MQD. Providers are encouraged to call in "URGENT" requests to ensure timely review and response.
- The Referral and Prior Authorization process is communicated to providers via the bi-annual provider education and training sessions and as identified through feedback from grievance and appeal reports, Customer Service, Provider Services, Medicare Sales team, and external partners. During the education sessions, providers are provided with a Notification/Prior Authorization Quick Reference Guide to help them quickly identify services that require either a notification and/or a prior authorization. The referral and prior authorization process is also communicated through provider newsletters, Provider Administrative Guide, and other forms.
- UHC CP's Member Handbook includes a description of referral process and prior authorization process. As they are identified, members are educated about and/or reminded of the referral and prior authorization process.
- Network providers are notified regularly in writing and at least 30 days in advance of any drugs deleted and/or added to the formulary. These notifications are also available online at http://www.uhccommunityplan.com/health-professionals/hi/pharmacy-program.html. Changes are also communicated to providers via provider newsletters and/or bulletins and other forms of communication. Providers who wish to propose Preferred Drug List (PDL) suggestions are encouraged to forward the information to the UnitedHealthcare Community Plan director of Pharmacy Services by either mail or fax. Providers must furnish adequate documentation such as clinical studies from the medical literature in order for the request to be considered for PDL addition. This literature should include information documenting clinical necessity as well as therapeutic advantages over current PDL products. Suggestions are reviewed by the Pharmacy and Therapeutics Committee.
- Based on feedback from its network providers, UHC CP has changed its provider services model by offering direct servicing without going through a local vendor as done in the past. The newly formed provider advocate team has been trained to assist providers with educational needs, claims resolution, and contracting needs. This new model is designed to ensure that providers have access to the resources available to them and to ensure that claims are paid timely and accurately. Direct provider servicing aims to enhance the provider's experience.

Appendix A. Methodologies for Conducting EQR Activities

During 2014, HSAG, as the EQRO for the MQD, conducted the following EQR activities for the QUEST, QExA, and CCS health plans in accordance with applicable CMS protocols:

- A review of compliance with federal and State requirements for select structure and operations and quality measurement and improvement standard areas
- Validation of performance measures (i.e., HEDIS compliance audits)
- Validation of PIPs
- A survey of adult Medicaid enrollees using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

In addition, HSAG, on behalf of the MQD, conducted the child Medicaid CAHPS survey on a statewide sample of CHIP enrollees who met eligibility and enrollment criteria.

For each EQR activity conducted in 2014, this appendix presents the following information, as required by 42 CFR 438.364:

- Objectives
- Technical methods of data collection and analysis
- Descriptions of data obtained

Compliance Monitoring Review

Objectives

The BBA, as set forth in 42 CFR 438.358, requires that a state or its designee conduct a review to determine each MCO's and PIHP's compliance with federal managed care regulations and state standards. Oversight activities must focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries by the MCO/PIHP. To complete this requirement, HSAG—through its EQRO contract with the MQD—conducted a compliance evaluation of the QUEST, QExA, and CCS health plans. For the 2014 EQR compliance monitoring activity—the second year of a three-year cycle of compliance review activities for all plans except 'Ohana CCS—HSAG conducted a desk audit and an on-site review of each of the health plans to assess the degree to which the plans met federal managed care and State requirements in select standard areas. The primary objective of HSAG's 2014 review was to provide meaningful information to the MQD and the QUEST and QExA health plans regarding contract compliance with those standards.

The following six standards were assessed for compliance:

- Standard I Provider Selection
- Standard II Subcontracts and Delegation
- Standard III Credentialing
- Standard IV Quality Assessment and Performance Improvement
- Standard V Health Information Systems
- Standard VI Practice Guidelines

The findings from the desk audits and the on-site reviews were intended to provide the MQD and each health plan with a performance assessment and, when indicated, recommendations to be used to:

- Evaluate the quality and timeliness of, and access to, care furnished by the health plan.
- Monitor interventions that were implemented for improvement.
- Evaluate the plan's current structure, operations, and performance on key processes.
- Initiate targeted activities to ensure compliance or enhance current performance, as needed.
- Plan and provide technical assistance in areas noted to have substandard performance.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance monitoring follow-up reviews, HSAG, in collaboration with the MQD, developed a customized data collection tool to use in the review of each health plan. The content of the tool was based on applicable federal and State laws and regulations, the Hawaii QUEST Request for Proposal (2011-003) as amended as of July 1, 2012, the QUEST Expanded

Access Request for Proposal (2008-006) as amended as of July 1, 2013, and the CCS Request for Proposal (2013-007) as amended as of March 1, 2013.

HSAG conducted the compliance monitoring reviews in accordance with the CMS protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.

As allowed by 42 CFR 438.360, the MQD elected to operationalize its non-duplication strategy which enabled health plans to be "deemed" compliant for certain requirements within the practice guidelines and credentialing standards if certain conditions were met as described in the State's approved Quality Strategy. Detailed information on the deemed status of each health plan is contained in Appendix B of this report.

Description of Data Obtained

To assess the health plans' compliance with federal and State requirements, HSAG obtained information from a wide range of written documents including committee meeting agendas, minutes, and handouts; policies and procedures; reports; member and provider handbooks; delegation agreements and monitoring reports; and provider contract templates. For the record review conducted at the one health plan that was not deemed compliant for credentialing, HSAG generated audit samples based on data files that the health plan provided (i.e., listings of providers credentialed or recredentialed within the review time period). HSAG also obtained information for the compliance monitoring review through observation during the on-site review and through interaction, discussion, and interviews with key health plan staff members.

At the conclusion of each compliance review, HSAG provided the health plan and the MQD with a report of findings and any required corrective actions. The plan-specific results are summarized in Section 3 of this report.

Validation of Performance Measures—HEDIS Compliance Audits

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

The following table presents the State-selected HEDIS and performance measures and required methodology for the 2014 validation activities.

Table A-1—2014 Validated Measures (Measurement Year 2013)				
Validated Measure and Abbreviation	**QUEST Measure**	**QExA Measure**	**CCS Measure**	**Methodology**
Childhood Immunization Status—Combos 2 through 10 (CIS)	X			Hybrid*
Well-Child Visits in the First 15 Months of Life (W15)	X			Hybrid*
Breast Cancer Screening	X			Admin
Chlamydia Screening in Women (CHL)	X			Admin
Controlling High Blood Pressure (CBP)	X	X		Hybrid
Comprehensive Diabetes Care (CDC)	X	X		Hybrid*
Ambulatory Care (AMB)		X		Admin
Adults' Access to Preventive/Ambulatory Health Services (AAP)		X		Admin
Inpatient Utilization—General Hospital/Acute Care (IPU)		X		Admin
*Plan All-Cause Readmissions (PCR)***		X	X	Admin
Follow-Up After Hospitalization for Mental Illness (FUH)			X	Admin
Follow-Up with Assigned PCP After Hospitalization for Mental Illness (FUP)			X	Admin
Behavioral Health Assessment (BHA)			X	Admin
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)			X	Admin
Mental Health Utilization (MPT)			X	Admin
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			X	Admin
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)			X	Admin
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)			X	Admin
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)			X	Admin

**Kaiser received approval from the MQD to report CIS, W15, and several CDC indicators via the Administrative methodology. Kaiser was required to report the CDC Eye and Nephropathy indicators using the Hybrid methodology.*
***The PCR measure was not a Medicaid measure and was reported by the QExA plans and CCS using the Medicare weighting tables.*

Technical Methods of Data Collection and Analysis

HSAG conducted the validation of the QUEST, QExA, and CCS health plans' HEDIS and performance measures using selected methodologies presented in the *2014 NCQA HEDIS Compliance Audit Standards, Policies and Procedures, HEDIS Volume 5*. The measurement period reviewed for the health plans was concurrent (CY 2013) and followed the NCQA HEDIS timeline for reporting rates.

The same process was followed for each performance measure validation conducted by HSAG and included: (1) pre-review activities such as development of measure-specific work sheets and a review of completed plan responses to the HEDIS Record of Administration, Data Management, and Processes (Roadmap); and (2) on-site activities such as interviews with staff members, primary source verification, programming logic review and inspection of dated job logs, and computer database and file structure review.

HSAG validated the health plans' IS capabilities for accurate reporting. The review team focused specifically on aspects of the health plans' systems that could affect the selected measures. Items reviewed included coding and data capture, transfer, and entry processes for medical data; data capture, transfer, and entry processes for membership data; data capture, transfer, and entry processes for provider data; medical record data abstraction processes; the use of supplemental data sources; and data integration and measure calculation. If an area of noncompliance was noted with any IS standard, the audit team determined if the issue resulted in significant, minimal, or no impact to the final reported rate.

Each HEDIS measure verified by the HSAG review team for the QUEST, QExA, and CCS health plans received an audit result consistent with one of the four NCQA categories listed in the following table.

Table A-2—NCQA Audit Results

NCQA Category for Measure Audit Result	Meaning
R = Report	*A rate or numeric result.* The MCO followed the specifications and produced a reportable rate or result for the measure.
NA = Not Applicable	*Small Denominator*. The MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB = No Benefit	*Benefit Not Offered.* The MCO did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR = Not Reportable	*Not Reportable.* 1. The calculated rate was materially biased, ***or*** 2. The MCO chose not to report the measure, ***or*** 3. The MCO was not required to report the measure.

For the purposes of comparison and assessment of improvement over time as depicted in this report, HSAG used the Pearson's Chi-square (X^2) test to examine whether statistically significant differences between HEDIS 2013 (CY 2012) rates and HEDIS 2014 (CY 2013) rates existed. A

difference was considered statistically significant if the *p* value was less than 0.05. Statistical significance testing was only performed on measures where rates are presented as a percentage. Trend analysis will not report any significant testing results for measures using per 1,000 member months (e.g., *Ambulatory Care*) as reporting units. Measures with statistically significant improvement were denoted in green, showing the magnitude of the percentage point differences. Similarly, measures with statistically significant decline were denoted in red. For inverse measures where a lower rate indicates better performance (e.g., *Comprehensive Diabetes Care—HbA1c Poor Control*), a statistically significant decline was shown in red with positive percentage point differences. Conversely, a statistically significant improvement was shown in green with negative percentage point differences. Measures for which there was no statistically significant change were shown with the percentage point increase or decrease in black.

Description of Data Obtained

HSAG used a number of different methods and sources of information to conduct the validation. These included:

- Completed responses to the HEDIS Roadmap published by NCQA as Appendix 2 to the *HEDIS 2014, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.
- Source code, computer programming, and query language (if applicable) used by the health plans to calculate the selected measures.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Re-abstraction of a sample of medical records selected by HSAG auditors for the health plans.

Information was also obtained through interaction, discussion, and formal interviews with key staff members, as well as through system demonstrations and data processing observations.

After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for the MQD and each health plan. The plan-specific results are summarized in Section 3 of this report; and in Section 4, a comparison of all plans' results to the MQD Quality Strategy targets is provided.

Validation of Performance Improvement Projects

Objectives

As part of the State's quality strategy, each QUEST, QExA, and CCS health plan was required by the MQD to conduct PIPs in accordance with 42 CFR 438.240. The purpose of these PIPs was to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical care and services and in nonclinical areas. As one of the mandatory EQR activities required under the BBA, HSAG, as the State's EQRO, validated the PIPs through an independent review process that followed the CMS protocol. The primary objective of the PIP validation was to determine compliance with requirements set forth in 42 CFR 438.240, including:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

In 2014, HSAG performed the validation activities on 16 PIPs submitted by the Hawaii Medicaid health plans, as described in the following table:

Table A-3—2014 Validated PIPs

Health Plan	PIP Topic
AlohaCare QUEST	1. *All-Cause Readmissions* 2. *Diabetes Care*
HMSA QUEST	1. *All-Cause Readmissions* 2. *Diabetes Care*
Kaiser QUEST	1. *All-Cause Readmissions* 2. *Diabetes Care*
'Ohana QExA	1. *Diabetes Care* 2. *Assessing the Documentation of Body Mass Index (BMI)*
'Ohana QUEST	1. *All-Cause Readmissions* 2. *Diabetes Care*
'Ohana CCS	1. *Follow-Up After Hospitalization for Mental Illness* 2. *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
UnitedHealthcare Community Plan QExA	1. *Diabetes Care* 2. *Assessing the Documentation of Body Mass Index (BMI)*
UnitedHealthcare Community Plan QUEST	1. *All-Cause Readmissions* 2. *Diabetes Care*

While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of processes for conducting PIPs, HSAG also identified that the health plans' PIPs contained

study indicators related to the quality, access, and timeliness domains. More specifically, all 16 PIPs provided opportunities for the health plans to improve the quality of care for their members.

Technical Methods of Data Collection and Analysis

The methodology HSAG used to validate the PIPs was based on the CMS protocol as outlined in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

HSAG, in collaboration with the MQD, developed the PIP Summary Form to be consistent with CMS' established protocols for conducting PIPs and to assist the QUEST, QExA, and CCS health plans in meeting compliance requirements. The health plans were provided the PIP Summary Form to complete and submit to HSAG for review.

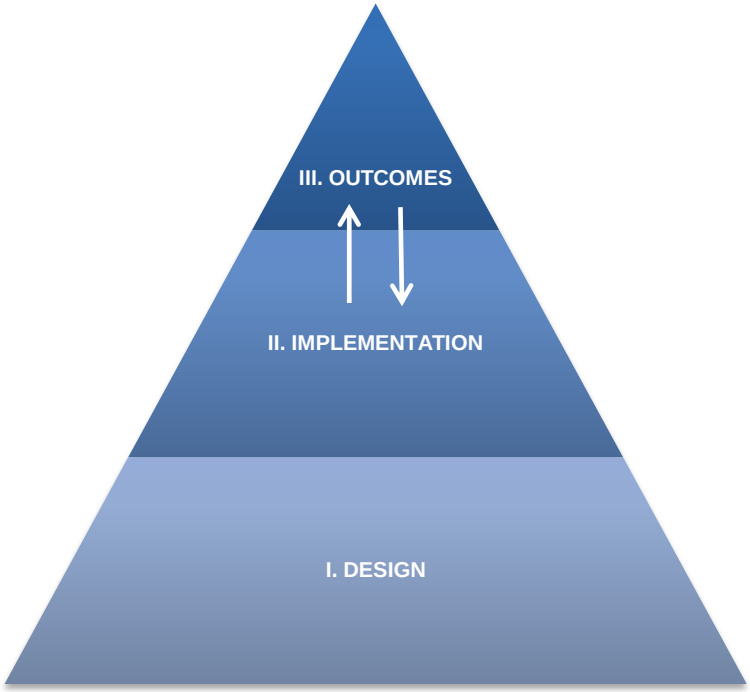
HSAG obtained the data needed to conduct the PIP validations from the health plans' PIP Summary Forms. These forms provided detailed information about each health plan's PIPs related to the activities completed, and HSAG evaluated for the 2014 validation cycle.

Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements had to be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. A health plan would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements was or were *Partially Met*. HSAG provided a *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*. Figure A-1 illustrates the three study stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage.

The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the study topic, question, population, indicators, sampling and data collection. To implement successful improvement strategies, a strong study design is necessary.

Figure A-1—PIP Study Stages



Once the health plan establishes its study design, the PIP process moves into the Implementation stage. This stage includes data analysis and interventions. During this stage, the health plans analyze data, identify barriers to performance, and develop interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve PIP outcomes.

The final stage is Outcomes, which involves the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over time and multiple measurements. This stage is the culmination of the previous two stages. The health plan should regularly evaluate interventions to ensure they are having the desired effect. A concurrent review of the data is encouraged. If the health plan's evaluation of the interventions, and/or review of the data, indicates that the interventions are not having the desired effect, the health plan should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Surveys

Objectives

The primary objective of the Adult CAHPS survey was to effectively and efficiently obtain information on the levels of satisfaction of the Hawaii Medicaid adult members with their health plan and health care experiences. Results were provided at both plan-specific and statewide aggregate levels.

The primary objective of the Child CAHPS survey was to obtain satisfaction information from the Hawaii CHIP population to provide to the MQD and to meet the State's obligation for CHIP CAHPS measure reporting to CMS. Results were provided to the MQD in a statewide aggregate report.

Technical Methods of Data Collection and Analysis

Data collection for the Adult CAHPS survey was accomplished through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey instrument to adult members of the QUEST and QExA health plans. Adult members included as eligible for the survey were 18 years of age and older as of December 31, 2013. All members were surveyed from March to May 2014 and received an English version of the survey. The participating QUEST plans included AlohaCare, HMSA, Kaiser, 'Ohana, and UnitedHealthcare Community Plan. The participating QExA plans included 'Ohana and UnitedHealthcare Community Plan. The 'Ohana CCS program enrollees were not separately sampled as they were already included in the population sampled for the QExA plan in which they were enrolled ('Ohana or UHC CP).

Data collection for Child CAHPS survey was accomplished through the administration of the CAHPS 5.0H Child Medicaid Health Plan Survey (without the children with chronic conditions [CCC] measurement set) to CHIP members of the QUEST health plans. The parents or caretakers of CHIP members enrolled in the QUEST health plans completed the surveys from March to May 2014. The children included as eligible for the survey were 17 years of age or younger as of December 31, 2013. All members sampled received an English version of the survey.

The Adult CAHPS survey included a set of standardized items (58 questions) that assessed members' perspectives on their health care. The Child CAHPS survey also included a set of standardized items (48 questions) that assessed parents'/caretakers' perspectives on their child member's care. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed to select the adult and child members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. An analysis of the CAHPS 5.0H Adult and Child Medicaid Health Plan Survey results was conducted using NCQA

HEDIS Specifications for Survey Measures.[A-1] NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result; however, for purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with an asterisk (*).

The survey questions were categorized into 11 measures of satisfaction. These measures included four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., Getting Needed Care or Getting Care Quickly). The individual item measures are individual questions that consider a specific area of care (i.e., Coordination of Care and Health Promotion and Education).

It is important to note that the CAHPS 5.0 Medicaid Health Plan Surveys were released by the Agency for Healthcare Research and Quality (AHRQ) in 2012. Based on the CAHPS 5.0 versions, NCQA introduced new HEDIS versions of the Adult and Child CAHPS Health Plan Surveys in August 2012. The following is a summary of the changes resulting from the transition to the CAHPS 5.0H Medicaid Health Plan Surveys.

With the transition from the CAHPS 4.0H to 5.0H Surveys, there were no changes made to the four CAHPS global ratings: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. The question language, response options, and placement of the global ratings remain the same; therefore, comparisons to national data and prior year's rates were performed for all four global ratings.

For three of the five composite measures (*Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), minor to no changes were made to the question language; therefore, comparisons to national data and prior year's rates were performed for these composite measures. For the *Getting Needed Care* composite measure, changes were made to the question language and placement of questions included in the composite. While comparisons to national data and prior year's rates were performed for this composite measure, the changes to the question language and reordering of questions may affect survey results for the adult QUEST and QExA health plans; therefore, caution should be exercised when interpreting the plans' results of the *Getting Needed Care* composite measure. For the *Shared Decision Making* composite measure, changes were made to the question language, response options, and number of questions. All items in the composite measure were reworded to ask about "starting or stopping a prescription medicine," whereas previously the items asked about "choices for your treatment of health care." Response options for these questions were revised to accommodate the new question language. Also, one question was added to the composite. Due to these changes, for the adult QUEST and QExA health plans, comparisons to national data and prior year's rates could not be performed for the *Shared Decision Making* composite measure. For the statewide CHIP population, comparisons to national data also could not be performed for the *Shared Decision Making* composite measure.

[A-1] National Committee for Quality Assurance. *HEDIS® 2014, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2013.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction rating (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate. In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (i.e., 1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite questions' response choices fell into one of the following three categories: (1) "Never," "Sometimes," "Usually," and "Always;" (2) "Not at all," "A little," "Some," and "A lot;" or (3) "No" and "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "A lot/Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures.

In addition to the global proportions, a three-point mean was calculated for each of the composite measures. Scoring was based on a three-point scale. Responses of "Usually/Always" and "A lot/Yes" were given a score of 3, responses of "Sometimes" and "Some" were given a score of 2, and all other responses were given a score of 1. The three-point mean was the average of the mean score for each question included in the composite.

The resulting three-point mean scores were compared to NCQA's 2014 HEDIS Benchmarks and Thresholds for Accreditation, except for the Shared Decision Making composite.[A-2] NCQA does not publish benchmarks and thresholds for the Shared Decision Making composite; therefore, star ratings could not be derived for this composite measure. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating and five being the highest possible rating, using the following percentile distributions:

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

Additionally, HSAG performed a trend analysis of participating QUEST and QExA health plans' and the statewide CHIP results. The QUEST and QExA health plans' 2014 CAHPS scores were compared to their corresponding 2012 CAHPS scores, where appropriate, to determine whether there were statistically significant differences.[A-3,A-4] For the statewide CHIP population, 2014 CAHPS scores were compared to their corresponding 2013 CAHPS scores to determine whether

[A-2] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA, January 30, 2014.
[A-3] 2014 represents the first year adult members of the 'Ohana and UnitedHealthcare Community Plan QUEST health plans were surveyed; therefore, a trend analysis could not be performed for these plans.
[A-3] HSAG did not survey the adult population in 2013.

there were statistically significant differences. Lastly, the QUEST health plans' and the QUEST statewide aggregate's as well as QExA health plans' and the QExA statewide aggregate's 2014 CAHPS scores were compared to 2013 NCQA National Adult Medicaid averages. The statewide CHIP population's 2014 CAHPS scores were compared to 2013 NCQA National Child Medicaid averages. These comparisons were performed for the four global ratings and four composite measures.

Description of Data Obtained

The CAHPS survey asks members to report on and to evaluate their experiences with health care. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The adults' and children's surveys were administered from March to May 2014 and were designed to achieve the highest possible response rate. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated (adult population only). Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the Adult and Child CAHPS surveys, HSAG provided each health plan and the MQD with a plan-specific report of findings; and a statewide aggregate report was provided to the MQD. The MQD also received a statewide aggregate report of the CHIP survey results.

The plan-specific results of the Adult CAHPS survey are summarized in Section 3 of this report; and in Section 4, a statewide comparison of all plan results is provided.

Appendix B. Documentation of Deemed Compliance for Review of Select Standards

Following this page is documentation of the MQD's data collection and decision-making processes for deeming plans compliant based on their NCQA accreditation status and full compliance with select standards and requirements in the areas of practice guidelines and credentialing. The MQD based its decisions on the step procedures as documented in its Quality Strategy and related Non-duplication Strategy report recommendations, both available on the MQD's Web site at http://www.med-quest.us/ManagedCare/qualitystrategy.html.

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

March 17, 2014

Ms. Bonnie Marsh
Health Services Advisory Group (HSAG)
1440 Kapiolani Boulevard, Suite 1110
Honolulu, Hawaii 96814

Dear Ms. Marsh:

The Department of Human Services (DHS), Med-QUEST Division (MQD) reviewed the "Checklist for Implementation of the Non-duplication Strategy for Limited Deemed Compliance During the 2014 Hawaii Compliance Reviews" created by HSAG for QUEST and QUEST Expanded Access (QExA) health plan compliance reviews for 2014.

MQD agrees with the following recommendations:

- Allow deeming for practice guidelines for five (5) QUEST health plans (AlohaCare, HMSA, Kaiser Permanente, 'Ohana Health Plan, and UnitedHealthcare Community Plan);

- Allow deeming for practice guidelines for two (2) QExA health plans ('Ohana Health Plan and UnitedHealthcare Community Plan);

- Allow deeming for the National Committee for Quality Assurance (NCQA) standards portion of credentialing for four (4) QUEST health plans (HMSA, Kaiser Permanente, 'Ohana Health Plan, and UnitedHealthcare Community Plan); and

- Allow deeming for the NCQA standards portion of credentialing for two (2) QExA health plans ('Ohana Health Plan and UnitedHealthcare Community Plan).

MQD will not allow deeming of the NCQA standards portion of credentialing for AlohaCare since NCQA only conducted an interim health plan survey that reviewed select credentialing standards with no file review performed. Therefore, HSAG will need to perform a complete compliance review on AlohaCare's credentialing process. In addition, HSAG shall perform

compliance review for credentialing for the DHS standards for all five (5) QUEST health plans and two (2) QExA health plans.

Please contact Patti Bazin via e-mail at pbazin@medicaid.dhs.state.hi.us or call her at 692-8083 should you have any questions.

Sincerely,

Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

Enclosure

HSAG HEALTH SERVICES ADVISORY GROUP

Checklist for Implementation of the Non-duplication Strategy for Limited Deemed Compliance During the 2014 Hawaii Compliance Reviews

(Steps included below are those outlined in the September 2009 report, *"Deemed Status: A Recommended Strategy for the Med-QUEST Division" as referenced in the State's Quality Strategy*)

Step 1: State Quality Strategy identifies deemable standards

Requirement: The State must identify in its quality strategy (QS) the standards for which it will use information from a Medicare or private accreditation organization review and the rationale for why it is duplicative of the State's or EQRO's review. Only those standards included in the quality strategy as submitted to CMS are eligible for consideration of deemed compliance. The MQD utilizes cross-walks to demonstrate equivalency and duplication of standards which will be deemable.

Requirement is **MET**. The State's approved QS meets this requirement and is posted at http://www.med-quest.us/ManagedCare/qualitystrategy.html . The scope of the deemable standards is limited to Credentialing and Practice Guidelines.

Step 2: Health Plan achieves compliance (State or EQRO review) with deemable standards

Requirement: To be considered for deemed compliance, the QUEST or QExA plan must have had at least one full review of compliance for the deemable standards by the State or its EQRO within the previous three year period. All standards must have been found fully compliant or must have been brought into full compliance through implementation of a corrective action plan (CAP) within the three year period.

Requirement is **MET**. Each of the five health plans has attained full compliance in Credentialing and Practice Guidelines standards within the previous 3-year compliance review cycle. Full compliance was attained either upon initial review or through subsequent corrective actions. Review results are documented in the Annual Report of EQR Results for CYs 2010 and 2011 (for practice guidelines) and CYs 2011 and 2012 (for credentialing) delivered to the MQD. The annual reports are also posted on the MQD's Web site at http://www.med-quest.us/ManagedCare/consumerguides.html.

Step 3: Health Plan is reviewed by an accrediting organization and achieves full compliance with deemable standards

Requirement: To be considered for deemed compliance, the QUEST or QExA plan must have achieved a favorable rating from the accrediting organization within the previous three year period, and all standards must have been found fully compliant or must have been brought into full compliance through implementation of a CAP within the three year period.

Requirement is **MET** for 4 of 5 health plans. See Table 1 at the end of this checklist for detailed information on each plan's scores achieved during their most recent accreditation review in the two areas eligible for deemed compliance. Supporting documentation from the accrediting organization (NCQA) is also attached.

Step 4: Health Plan is fully accredited by a CMS approved organization

Requirement: To be considered for deemed compliance, the QUEST or QExA plan must be fully accredited (or certified, in the case of Medicare) within the previous three year period, and must be in good standing with the accrediting or certifying body. CMS currently recognizes the following organizations as approved for purposes of this deeming option: NCQA, JCAHO, AHC, URAC, Medicare.

Requirement is **MET** for 4 of 5 health plans. See Table 2 at the end of this checklist for detailed information on each plan's NCQA accreditation status. Health plan accreditation certificates are also attached.

Step 5: Health Plan provides accreditation review results to MQD

Requirement: To be considered for deemed compliance, the QUEST or QExA plan must furnish to the MQD all documentation of accrediting body review results that pertain to the areas or standards that are being considered for deemed compliance. Results must include reports of findings, recommendations, required corrective actions, implementation of corrective actions, sanctions from the organization, as well as a copy of the health plan's accreditation certificate with effective dates and status.

Requirement is **MET.** The MQD delegated this responsibility to HSAG for purposes of assembling this checklist and supporting documents. HSAG requested and received the information from the plans and has compiled the accreditation scores, certificates, and accreditation status information as an attachment to this checklist for the MQD.

Step 6: MQD provides review results to EQRO

Requirement: The MQD will timely provide a copy of the above documentation to the State's EQRO, for inclusion in its evaluation of the health plan. The findings will be used as supplemental information for the EQRO's compliance review of the health plan, in order to prevent duplication of the deemable standards.

Requirement is **MET**. As described in Step 5, HSAG received the accreditation review results directly from each health plan. The MQD made the decision as to each plan's eligibility for deemed compliance in the select standard areas (credentialing and practice guidelines) based on its review of this checklist and the supporting documentation. For plans allowed by the MQD to be deemed compliant for one or both standards, HSAG will incorporate that information into its review tool and process during the 2014 compliance reviews. For any plans that are not deemed compliant by the MQD for one or both standards, HSAG will conduct a review of compliance in the standard area(s).

Step 7: EQRO uses results in State's annual EQR report

Requirement: The EQRO will also use the report of findings in its external quality review of the health plan's provision of timely, accessible, and quality services to its Medicaid members. This report, as defined at 42CFR438.364 is an annual requirement and is produced by the EQRO for the State as a deliverable to CMS.

Requirement is **MET**. HSAG provides all health plan compliance results (scores, strengths, areas for correction or improvement) within the Annual Report of EQR Results every year, as demonstrated in these reports posted on the MQD's Web site. The MQD has opted to also include this checklist and supporting documentation as an appendix to the 2014 Annual report as further demonstration to CMS of MQD's adherence to its Quality Strategy for non-duplication of efforts.

Table 1 – Health Plan results of reviews by NCQA for Credentialing and Practice Guidelines (reference Step 3)					
	AlohaCare	HMSA	Kaiser	Ohana	UHC CP
Credentialing score	N/A*	100%	100%	100%	98.20%**
CAP required?	N/A	NO	NO	NO	NO
Met CAP requirements?	N/A	N/A	N/A	N/A	N/A
Practice Guidelines score	100%*	100%	100%	100%	100%
CAP required?	NO	NO	NO	NO	NO
Met CAP requirements?	N/A	N/A	N/A	N/A	N/A
Date of most recent survey	11/19/13	5/7/13	4/30/13	3/28/12	4/11/12

*For its accreditation review, AlohaCare elected the Interim Survey evaluation option, wherein only select Credentialing standards were reviewed by NCQA and no file review was performed. As such, AlohaCare does not meet the criteria for deemed compliance in this area and will undergo a full Credentialing standards review and file review during the 2014 EQRO compliance review. The health plan was reviewed by NCQA for all Practice Guidelines standards that were relevant to the Medicaid contract, therefore, this area can be deemed compliant.

**Additional documentation was obtained from UHC CP to ensure one item was subsequently fully met (CR3, Element B, #3 regarding primary source verification of work history).

Table 2 – Health Plan Accreditation Status (reference Step #4)					
	AlohaCare	HMSA	Kaiser	Ohana	UHC CP
Accreditation status	Accredited	Commendable	Excellent	Accredited	Accredited
Accredited as	Medicaid HMO	Medicaid HMO	Medicaid HMO	Medicaid HMO	Medicaid HMO
Standards reviewed***	2013 HP Interim Survey	2012 HP	2012 HP	2011 NHP	2011 NHP
Date granted	2/13/14	6/10/13	4/30/13	3/28/12	4/11/12
Expiration date	8/13/15	6/10/16	4/30/16	3/28/15	4/11/15

***Indicates the applicable year and type of standards reviewed: NCQA Standards and Guidelines for the Accreditation of Health Plans (HP) or New Health Plans (NHP). AlohaCare elected the Interim Survey option, wherein only select standards were reviewed by NCQA and an 18 month (as opposed to a full 3 year) accreditation was granted. The Interim Survey option does not meet the criterion for "fully accredited" as described in Step 4 of the Non-duplication Strategy in the State's Quality Strategy.

Compiled information current as of 3/12/14

AlohaCare

HSAG HEALTH SERVICES ADVISORY GROUP

INFORMATION REQUEST

Health plan name: AlohaCare

Date of most recent NCQA accreditation review (must be within the past 3 years): Survey date was 11/19/13

Accreditation status and rating received:
Interim Accreditation Pending – awaiting final Review Oversight Committee decision which is expected by mid-February. Preliminary report score 47.82 out of 50 points (35 points needed for accreditation).

During the review, health plan was reviewed for *Credentialing* and met all standards: **YES** X **NO** ☐

If NO, was a plan of correction required and completed? **YES** ☐ **NO** ☐

During the review, health plan was reviewed for *Practice Guidelines* and met all standards: **YES** X **NO** ☐

If NO, was a plan of correction required and completed? **YES** ☐ **NO** ☐

Name and contact information of person providing this information:

Frank Appel
808-973-2556
fappel@alohacare.org

When submitting this information, please include the following:

- *Copy of the plan's current NCQA certificate of accreditation*: Certificate expected in mid-February
- *Copy of the NCQA report of findings for the areas of Credentialing and Practice Guidelines*: copy attached. Credentialing and Practice Guidelines (QI 9) scored 100%.
- *Copy of any plan of correction required and implemented for the Credentialing and Practice Guidelines standards, if applicable, and indication of status of the items*: not applicable

Please send this form and all of the above to me at:

MAIL	OR	EMAIL	OR	FAX
Bonnie Marsh, BSN, MA ***Health Services Advisory Group*** ***1440 Kapiolani Blvd, Ste. 1110*** ***Honolulu, HI 96814***		***bmarsh@hsag.com***		***(808)941-5333***

1/27/14
bjm

National Committee for Quality Assurance

has awarded

AlohaCare

Medicaid HMO

Interim Health Plan Evaluation

for basic structure and processes in place to meet expectations for consumer protection and quality improvement.

CHAIR BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

February 13, 2014	August 13, 2015
DATE GRANTED	EXPIRATION DATE

2013 Standards and Guidelines for the Accreditation of Health Plans Medicaid HMO

Return to category results

Results by Standard

Note: The Possible Points below reflect any points reallocated as a result of any Not Applicable Standards or Elements (including delegation for example). Any Elements that are incomplete are scored as 0.00 points.

Click on the category link below to view results for each element in the category.

Quality Management and Improvement	POINTS RECEIVED	POSSIBLE POINTS
QI1: Program Structure	0.45	0.91
QI2: Program Operations	1.16	1.16
QI3: Health Services Contracting	2.63	2.63
QI7: Complex Case Management	3.03	3.03
QI8: Disease Management	2.83	2.83
QI9: Practice Guidelines	6.47	6.47
QI12: Delegation of QI	NA	NA
category total:	16.59	17.05

Utilization Management	POINTS RECEIVED	POSSIBLE POINTS
UM1: UM Program Structure	1.01	1.01
UM2: Clinical Criteria for UM Decisions	1.92	1.92
UM3: Communication Services	0.50	0.50

UM4: Appropriate Professionals	1.56	1.56
UM5: Timeliness of UM Decisions	3.84	3.84
UM8: Policies for Appeals	2.02	2.02
UM10: Evaluation of New Technology	1.21	1.21
UM12: Emergency Services	0.80	0.80
UM13: Procedures for Pharmaceutical Management	1.77	1.77
UM14: Triage and Referral for Behavioral Healthcare	NA	NA
UM15: Delegation of UM	NA	NA
category total:	14.67	14.67

Credentialing	POINTS RECEIVED	POSSIBLE POINTS
CR1: Credentialing Policies	2.04	2.04
CR2: Credentialing Committee	1.22	1.22
CR5: Practitioner Office Site Quality	1.41	1.41
CR7: Notification to Authorities and Practitioner Appeal Rights	1.63	1.63
CR8: Assessment of Organizational Providers	1.63	1.63
CR9: Delegation of CR	0.88	0.88
category total:	8.85	8.85

Members' Rights and Responsibilities	POINTS RECEIVED	POSSIBLE POINTS
RR1: Statement of Members' Rights and Responsibilities	1.11	1.11
RR2: Policies for Complaints and Appeals	3.34	3.34
RR3: Subscriber Information	2.22	2.22
RR5: Privacy and Confidentiality	1.01	1.01
RR6: Marketing Information	0.00	1.72
RR7: Delegation of RR	NA	NA
category total:	7.69	9.41

Medicaid	POINTS RECEIVED	POSSIBLE POINTS
MED1: Medicaid Benefits and Services	0.00	0.00

From: Frank Appel [mailto:fappel@alohacare.org]
Sent: Monday, February 24, 2014 3:38 PM
To: Bonnie Marsh
Cc: Jonathan Cascino
Subject: NCQA Notification

Bonnie,
We received our official accreditation notice today:

2013 Standards and Guidelines for the Accreditation of Health Plans

Name:	AlohaCare		
Evaluation Option:	Interim Survey		
Standards Year:	2013		
Product Line/Product	**Overall Score**	**Status**	**Valid Dates**
Medicaid HMO (Performance Measures Data: NA)	47.82 out of 50.00	Interim	2/13/2014 - 8/13/2015

Our final scores related to Practice Guidelines and Credentialing are:

QI9: Practice Guidelines

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	3.23	3.23	100.00
Element B	3.23	3.23	100.00

CR1: Credentialing Policies

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	1.22	1.22	100.00
Element B	0.81	0.81	100.00

CR2: Credentialing Committee

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	1.22	1.22	100.00

CR5: Practitioner Office Site Quality

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	1.41	1.41	100.00

CR7: Notification to Authorities and Practitioner Appeal Rights

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	1.63	1.63	100.00
Element B	NA	NA	NA
Element C	NA	NA	NA

CR8: Assessment of Organizational Providers

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	0.81	0.81	100.00
Element B	0.40	0.40	100.00
Element C	0.40	0.40	100.00

CR9: Delegation of CR

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	0.41	0.41	100.00
Element B	0.47	0.47	100.00
Element C	NA	NA	NA
Element D	NA	NA	NA

As you know, under the Interim Survey, some standards/elements are not applicable, so not all of the standards were scored. This would certainly affect which standards would be considered for deeming.

Let me know if you have any questions or need more information.

Aloha,

Frank Appel
Sr. Director, Quality Improvement
AlohaCare
1357 Kapi'olani Blvd. Suite 1250
Honolulu HI 96814
(808)973-2556
fappel@alohacare.org

HMSA

INFORMATION REQUEST

Health plan name: Hawaii Medical Service Association

Date of most recent NCQA accreditation review (must be within the past 3 years): May 6 - 7, 2013 On-site Survey March 19, 2013 ISS Submission

Accreditation status and rating received: Commendable; granted June 10, 2013 and expires June 10, 2016

During the review, health plan was reviewed for *Credentialing* and met all standards: YES ☒ NO ☐

If NO, was a plan of correction required and completed? YES ☐ NO ☐

During the review, health plan was reviewed for *Practice Guidelines* and met all standards: YES ☒ NO ☐

If NO, was a plan of correction required and completed? YES ☐ NO ☐

Name and contact information of person providing this information:

Aubrey Pucan Hester, QI Specialist, 948-6289 aubrey_pucan@hmsa.com

When submitting this information, please include the following:

- *Copy of the plan's current NCQA certificate of accreditation* Attached
- *Copy of the NCQA report of findings for the areas of Credentialing and Practice Guidelines* N/A
- *Copy of any plan of correction required and implemented for the Credentialing and Practice Guidelines standards, if applicable, and indication of status of the items* N/A

Please send this form and all of the above to me at:

MAIL	OR	EMAIL	OR	FAX
Bonnie Marsh, BSN, MA ***Health Services Advisory Group*** ***1440 Kapiolani Blvd, Ste. 1110*** ***Honolulu, HI 96814***		***bmarsh@hsag.com***		***(808)941-5333***

1/27/14
bjm

National Committee for Quality Assurance

has awarded

Hawaii Medical Service Association (HMSA)

Medicaid-HMO

an accreditation status of

COMMENDABLE

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

CHAIR BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

June 10, 2013

DATE GRANTED

June 10, 2016

EXPIRATION DATE

2012 Standards and Guidelines for the Accreditation of Health Plans Medicaid HMO

Return to category results

Results by Standard

Note: The Possible Points below reflect any points reallocated as a result of any Not Applicable Standards or Elements (including delegation for example). Any Elements that are incomplete are scored as 0.00 points.

Click on the category link below to view results for each element in the category.

Quality Management and Improvement	POINTS RECEIVED	POSSIBLE POINTS
QI1: Program Structure	0.45	0.45
QI2: Program Operations	0.45	0.45
QI3: Health Services Contracting	0.81	0.81
QI4: Availability of Practitioners	1.54	1.54
QI5: Accessibility of Services	1.27	1.27
QI6: Member Satisfaction	2.54	2.54
QI7: Complex Case Management	1.72	1.72
QI8: Disease Management	1.90	1.90
QI9: Clinical Practice Guidelines	1.81	1.81
QI10: Continuity and Coordination of Medical Care	0.99	0.99
QI11: Continuity and Coordination Between Medical Care and Behavioral Healthcare	0.81	0.81
QI12: Delegation of QI	1.59	1.59

category total: 15.93 15.93

Credentialing

	POINTS RECEIVED	POSSIBLE POINTS
CR1: Credentialing Policies	**0.50**	0.50
CR2: Credentialing Committee	**0.30**	0.30
CR3: Initial Credentialing Verification	**1.10**	1.10
CR4: Application and Attestation	**0.35**	0.35
CR5: Initial Sanction Information	**0.75**	0.75
CR6: Practitioner Office Site Quality	**1.21**	1.21
CR7: Recredentialing Verification	**1.66**	1.66
CR8: Recredentialing Cycle Length	**0.35**	0.35
CR9: Ongoing Monitoring	**1.41**	1.41
CR10: Notification to Authorities and Practitioner Appeal Rights	**0.40**	0.40

CR11: Assessment of Organizational Providers	**0.60**	0.60
CR12: Delegation of CR	**NA**	NA
category total:	**8.67**	8.67

Kaiser

INFORMATION REQUEST

Health plan name: _ Kaiser Foundation Health Plan, Inc. - Hawaii _____

Date of most recent NCQA accreditation review (must be within the past 3 years): _April 30, 2013_____

Accreditation status and rating received: _ Excellent status / rating _____

During the review, health plan was reviewed for *Credentialing* and met all standards: **YES** ☑ **NO** ☐

If NO, was a plan of correction required and completed? **YES** ☐ **NO** ☐

During the review, health plan was reviewed for *Practice Guidelines* and met all standards: **YES** ☑ **NO** ☐

If NO, was a plan of correction required and completed? **YES** ☐ **NO** ☐

Name and contact information of person providing this information:

__Susan T. Wilson, Quality Management Manager, phone # 432-3611; email Susan.T.Wilson@kp.org_____
address: Kaiser Permanente Kapolei Clinic, 599 Farrington Hwy, Kapolei, 96707 _____

When submitting this information, please include the following:

- *Copy of the plan's current NCQA certificate of accreditation*
- *Copy of the NCQA report of findings for the areas of Credentialing and Practice Guidelines*
- *Copy of any plan of correction required and implemented for the Credentialing and Practice Guidelines standards, if applicable, and indication of status of the items*

Please send this form and all of the above to me at:

MAIL	OR	EMAIL	OR	FAX
Bonnie Marsh, BSN, MA ***Health Services Advisory Group*** ***1440 Kapiolani Blvd, Ste. 1110*** ***Honolulu, HI 96814***		***bmarsh@hsag.com***		***(808)941-5333***

1/27/14
bjm

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Kaiser Foundation Health Plan, Inc. - Hawaii

Medicaid HMO

its highest accreditation status of

EXCELLENT

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.
This organization's HEDIS results are in the highest range of national performance.

CHAIR BOARD OF DIRECTORS

PRESIDENT

Duane E Davis MD.
CHAIR, REVIEW OVERSIGHT COMMITTEE

April 30, 2013
DATE GRANTED

April 30, 2016
EXPIRATION DATE

2012 Standards and Guidelines for the Accreditation of Health Plans Medicaid HMO

Return to category results | Return to Standard results

Note: The Possible Points below reflect any points reallocated as a result of any Not Applicable Standards or Elements (including delegation for example). Any Elements that are incomplete are scored as 0.00 points.

To view the Survey Tool, click on the link to the right of the Standard you wish to view.

To return directly to this page from the Survey Tool, use the "Back" button on your browser.

If you change any data in the Survey Tool when going back and forth, you may recalculate your numeric results by clicking the "Recalculate" button below:

Recalculate

CR1: Credentialing Policies	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.27	0.27	100.00	
Element B	0.18	0.18	100.00	

CR2: Credentialing Committee	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.09	0.09	100.00	
Element B	0.18	0.18	100.00	

CR3: Initial Credentialing Verification	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.49	0.49	100.00	
Element B	0.49	0.49	100.00	

CR4: Application and Attestation	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.31	0.31	100.00	

CR5: Initial Sanction Information	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.67	0.67	100.00	

CR6: Practitioner Office Site Quality	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.31	0.31	100.00	
Element B	0.76	0.76	100.00	

CR7: Recredentialing Verification	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.27	0.27	100.00	
Element B	0.27	0.27	100.00	
Element C	0.27	0.27	100.00	
Element D	0.67	0.67	100.00	

CR8: Recredentialing Cycle Length	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.31	0.31	100.00	

CR9: Ongoing Monitoring	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	1.26	1.26	100.00	

CR10: Notification to Authorities and Practitioner Appeal Rights	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.36	0.36	100.00	
Element B	NA	NA	NA	
Element C	NA	NA	NA	

CR11: Assessment of Organizational Providers	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.18	0.18	100.00	
Element B	0.09	0.09	100.00	
Element C	0.09	0.09	100.00	
Element D	0.09	0.09	100.00	
Element E	0.09	0.09	100.00	

CR12: Delegation of CR	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)	View Survey Tool
Element A	0.13	0.13	100.00	
Element B	NA	NA	NA	
Element C	0.13	0.13	100.00	

Element D	**NA**	**NA**	**NA**
Element E	**0.17**	**0.17**	**100.00**
Element F	**0.13**	**0.13**	**100.00**
Element G	**0.13**	**0.13**	**100.00**
Element H	**0.13**	**0.13**	**100.00**

Category Total:	**8.60**	**8.60**

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Element C	0.40	0.40	100.00
Element D	0.40	0.40	100.00

QI5: Accessibility of Services

View Survey Tool

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	0.36	0.36	100.00
Element B	0.45	0.45	100.00
Element C	0.45	0.45	100.00

QI6: Member Satisfaction

View Survey Tool

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	1.71	1.71	100.00
Element B	0.81	0.81	100.00

QI7: Complex Case Management

View Survey Tool

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	0.27	0.27	100.00
Element B	0.18	0.18	100.00
Element C	0.18	0.18	100.00
Element D	0.09	0.09	100.00
Element E	0.18	0.18	100.00
Element F	0.09	0.09	100.00
Element G	0.09	0.09	100.00
Element H	0.09	0.09	100.00
Element I	0.27	0.27	100.00
Element J	0.27	0.27	100.00

QI8: Disease Management

View Survey Tool

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	0.18	0.18	100.00
Element B	0.18	0.18	100.00
Element C	0.18	0.18	100.00
Element D	0.09	0.09	100.00
Element E	0.18	0.18	100.00
Element F	0.18	0.18	100.00
Element G	0.18	0.18	100.00
Element H	0.18	0.18	100.00
Element I	0.18	0.18	100.00
Element J	0.09	0.09	100.00
Element K	0.27	0.27	100.00

QI9: Clinical Practice Guidelines

View Survey Tool

	POINTS RECEIVED	POSSIBLE POINTS	PERCENTAGE SCORES (%)
Element A	1.08	1.08	100.00
Element B	0.18	0.18	100.00
Element C	0.54	0.54	100.00

‘Ohana

INFORMATION REQUEST

Health plan name: _____'Ohana Health Plan_____

Date of most recent NCQA accreditation review (must be within the past 3 years): ___March 28, 2012_____

Accreditation status and rating received: _____New Health Plan Accreditation_____

During the review, health plan was reviewed for *Credentialing* and met all standards: **YES** X **NO** ☐

If NO, was a plan of correction required and completed? **YES** ☐ **NO** ☐

During the review, health plan was reviewed for *Practice Guidelines* and met all standards: **YES** X **NO** ☐

If NO, was a plan of correction required and completed? **YES** ☐ **NO** ☐

Name and contact information of person providing this information:

_____June Mellor. Phone # (808) 675-7342. Email address: june.mellor@wellcare.com_____

When submitting this information, please include the following:

- *Copy of the plan's current NCQA certificate of accreditation*
- *Copy of the NCQA report of findings for the areas of Credentialing and Practice Guidelines*
- *Copy of any plan of correction required and implemented for the Credentialing and Practice Guidelines standards, if applicable, and indication of status of the items*

Please send this form and all of the above to me at:

MAIL	OR	**EMAIL**	OR	**FAX**
Bonnie Marsh, BSN, MA ***Health Services Advisory Group*** ***1440 Kapiolani Blvd, Ste. 1110*** ***Honolulu, HI 96814***		***bmarsh@hsag.com***		***(808)941-5333***

1/27/14
bjm

NCQA
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Improving health care.

National Committee for Quality Assurance

has awarded

WellCare Health Insurance of Arizona, Inc.
dba "Ohana Health Plan

the status of

New Health Plan Accreditation

for the development of a structurally sound managed health care delivery system which has as its primary objective the delivery of high quality member care and service.

CHAIR BOARD OF DIRECTORS

PRESIDENT

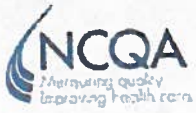
CHAIR, REVIEW OVERSIGHT COMMITTEE

March 28, 2012

DATE GRANTED

March 28, 2015

EXPIRATION DATE



2011 Standards and Guidelines for the Accreditation of New Health Plans

Results by category

Click on the category link below to view results for each Standard in a category.

Quality Management and Improvement	32.65	32.65	100.00%
Utilization Management	28.71	28.91	99.30%
Credentialing	19.21	19.21	100.00%
Members' Rights and Responsibilities	11.12	11.12	100.00%
Preventive Health	8.08	8.08	100.00%
Medicaid	0.00	0.00	0.00%
TOTAL	99.79	100.00	99.80%

*For display purposes only, all points are truncated to 2 decimal places. When actually scoring, NCQA does not round or truncate.

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2011 Standards and Guidelines for the Accreditation of New Health Plans

Return to category results

Results by Standard

Note: The Possible Points below reflect any points reallocated as a result of any Not Applicable Standards or Elements (including delegation for example). Any Elements that are incomplete are scored as 0.00 points.

Click on the category link below to view results for each element in the category.

Quality Management and Improvement	POINTS RECEIVED	POSSIBLE POINTS
QI1: Program Structure	3.03	3.03
QI2: Program Operations	3.53	3.53
QI3: Health Services Contracting	2.83	2.83
QI4: Availability of Practitioners	2.52	2.52
QI5: Accessibility of Services	4.85	4.85
QI6: Member Satisfaction	7.15	7.15
QI7: Complex Case Management	1.43	1.43
QI8: Disease Management	1.21	1.21
QI9: Clinical Practice Guidelines	1.41	1.41
QI10: Continuity and Coordination of Medical Care	1.61	1.61
QI11: Continuity and Coordination Between Medical and Behavioral Healthcare	1.01	1.01
QI12: Clinical Issues	2.02	2.02
QI13: Delegation of QI	NA	NA
category total:	32.65	32.65

Utilization Management	POINTS RECEIVED	POSSIBLE POINTS

UM1: Utilization Management Structure	2.02	2.02
UM2: Clinical Criteria for UM Decisions	2.02	2.02
UM3: Communication Services	0.50	0.50
UM4: Appropriate Professionals	2.02	2.02
UM5: Timeliness of UM Decisions	2.02	2.02
UM6: Clinical Information	1.71	1.71
UM7: Denial Notices	1.41	1.61
UM8: Policies for Appeals	1.01	1.01
UM9: Appropriate Handling of Appeals	8.08	8.08
UM10: Evaluation of New Technology	2.02	2.02
UM11: Satisfaction With the UM Process	3.43	3.43
UM12: Emergency Services	1.41	1.41
UM13: Procedures for Pharmaceutical Management	1.01	1.01
UM14: Triage and Referral for Behavioral Healthcare	NA	NA
UM15: Delegation of UM	NA	NA
category total:	28.71	28.91

Credentialing	POINTS RECEIVED	POSSIBLE POINTS
CR1: Credentialing Policies	2.27	2.27
CR2: Credentialing Committee	1.63	1.63
CR3: Initial Credentialing Verification	2.73	2.73
CR4: Application and Attestation	1.36	1.36
CR5: Initial Sanction Information	2.00	2.00
CR6: Practitioner Office Site Quality	1.36	1.36
CR7: Ongoing Monitoring	0.91	0.91
CR8: Notification to Authorities and Practitioner Appeal Rights	1.82	1.82
CR9: Assessment of Organizational Providers	3.18	3.18
CR10: Delegation of CR	1.92	1.92
category total:	19.21	19.21

Members' Rights and Responsibilities	POINTS RECEIVED	POSSIBLE POINTS
RR1: Statement of Members' Rights and Responsibilities	2.73	2.73
RR2: Distribution of Rights Statements to Members and Practitioners	1.01	1.01
RR3: Policies for Complaints and Appeals	2.02	2.02
RR4: Subscriber Information	2.02	2.02

UHC CP

INFORMATION REQUEST

Health plan name:
UnitedHealthcare Insurance Company dba UnitedHealthcare Community Plan (HI QExA and QUEST)

Date of most recent NCQA accreditation review (must be within the past 3 years): March 2012 (Valid Dates 04/11/2012 – 04/11/2015) with a partial review December 2012 to deem QUEST accredited along with the existing QExA plan

Accreditation status and rating received: Accredited with 98.90 out of 100.00

During the review, health plan was reviewed for *Credentialing* and met all standards: **YES** ☐ **NO X**

If NO, was a plan of correction required and completed? **YES** ☐ **NO X**
Files were found non-compliant for verification of work history for one delegated facility HPH (CR 3A.3). The Plan did pass the standard. No formal report of findings was received and no formal corrective action was required.

During the review, health plan was reviewed for *Practice Guidelines* and met all standards: **YES X NO** ☐

If NO, was a plan of correction required and completed? **YES X NO** ☐
N/A

Name and contact information of person providing this information:
Jan L. Henry, RN, JD; Compliance Officer jan_henry@uhc.com p. (808) 544.8852 f. (855) 299.1149
UnitedHealthcare Community Plan 841 Bishop Street, Suite 725 Honolulu, HI 96814

When submitting this information, please include the following:

- *Copy of the plan's current NCQA certificate of accreditation*
- *Copy of the NCQA report of findings for the areas of Credentialing and Practice Guidelines*
- *Copy of any plan of correction required and implemented for the Credentialing and Practice Guidelines standards, if applicable, and indication of status of the items*

See email attachments:

- NCQA Certification letter
- NCQA Accreditation Certificate
- NCQA Current Status
- NCQA Results Detail screen shots

Please send this form and all of the above to me at:

MAIL	OR	EMAIL	OR	FAX
Bonnie Marsh, BSN, MA *Health Services Advisory Group* *1440 Kapiolani Blvd, Ste. 1110* *Honolulu, HI 96814*		***bmarsh@hsag.com***		***(808)941-5333***

National Committee for Quality Assurance

has awarded

UnitedHealthcare Insurance Company dba UnitedHealthcare Community Plan (HI QExA)

the status of

New Health Plan Accreditation

for the development of a structurally sound managed health care delivery system which has as its primary objective the delivery of high quality member care and service.

CHAIR BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

April 11, 2012

DATE GRANTED

April 11, 2015

EXPIRATION DATE

Results Detail - 2011NHP Proj: 14595 UnitedHealthcare Insurance Company dba UnitedHealthcare Co - Windows Internet Explorer pro

https://iss.ncqa.org/RDSat/resultsDetail.asp?ProgramID=322&ProductLineID=-1

File Edit View Favorites Tools Help

Convert Select

Favorites UnitedHealth Windows 7@UHG

Page Safety Tools

Results Detail - 2011NHP Proj: 14595 UnitedHealt...

2011 Standards and Guidelines for the Accreditation of New Health Plans

Results by category

Click on the category link below to view results for each Standard in a category.

CATEGORY	Points Received	Possible Points	0% 20% 40% 60% 80% 100%
Quality Management and Improvement	33.50	33.50	100.00%
Utilization Management	28.93	29.66	97.52%
Credentialing	19.35	19.70	98.20%
Members' Rights and Responsibilities	8.81	8.81	100.00%
Preventive Health	8.29	8.29	100.00%
Medicaid	0.00	0.00	0.00%
TOTAL	98.90	100.00	98.91%

Done

Internet | Protected Mode: Off

90%

Results Detail - 2011NHP Proj: 14595 UnitedHealthcare Insurance Company dba UnitedHealthcare Co - Windows Internet Explorer pro

https://iss.ncqa.org/RDSat/resultsCatStandLev.asp?programID=322&ProductLineID=-1#C

File Edit View Favorites Tools Help

Convert Select

Favorites UnitedHealth Windows 7@UHG

Page Safety Tools

Results Detail - 2011NHP Proj: 14595 UnitedHealt...

Quality Management and Improvement

	POINTS RECEIVED	POSSIBLE POINTS
QI1: Program Structure	3.11	3.11
QI2: Program Operations	3.63	3.63
QI3: Health Services Contracting	2.90	2.90
QI4: Availability of Practitioners	2.59	2.59
QI5: Accessibility of Services	4.97	4.97
QI6: Member Satisfaction	7.34	7.34
QI7: Complex Case Management	1.47	1.47
QI8: Disease Management	1.24	1.24
QI9: Clinical Practice Guidelines	1.45	1.45
QI10: Continuity and Coordination of Medical Care	1.65	1.65
QI11: Continuity and Coordination Between Medical and Behavioral Healthcare	1.03	1.03
QI12: Clinical Issues	2.07	2.07
QI13: Delegation of QI	NA	NA
category total:	33.50	33 50

Internet | Protected Mode: Off

100%

Done

Date: 10:03 AM HST, 02/14/2014
From: Bonnie Marsh <BMarsh@hsag.com>
To: "store4763@theupsstore.com" <store4763@theupsstore.com>
Subject: Fwd: Request for Information by 2/7/14 (UHCCP Hawaii)

Sent from my iPhone

Begin forwarded message:

From: "Henry, Jan L" <jan_henry@uhc.com<mailto:jan_henry@uhc.com>>
Date: February 12, 2014 at 6:45:15 PM HST
To: Bonnie Marsh <BMarsh@hsag.com<mailto:BMarsh@hsag.com>>
Cc: "Herndon, David R" <david_herndon@uhc.com<mailto:david_herndon@uhc.com>>
Subject: RE: Request for Information by 2/7/14 (UHCCP Hawaii)

Bonnie,

As we recently reported, files related to CR 3, Element B were found non-compliant for verification of work history for Hawaii Pacific Health (HPH). I have included the Findings/Recommendations excerpt from the 2011 Annual Delegation Oversight Audit Report for the HPH entities below:
[cid:image001.png@01CF2705.D83C1650] (Att. #1)

The Findings/Recommendations excerpt from the subsequent 2012 Annual Delegation Oversight Audit Report for HPH are included below:
[cid:image002.png@01CF2705.D83C1650] (Att. #2)

I hope that this provides the information that you need to support the request for deemed compliance. Please let me know if you have additional questions.

Best regards,

Jan L. Henry, RN, JD
Compliance Officer
UnitedHealthcare Community Plan
841 Bishop Street, Suite 725
Honolulu, HI 96814
jan_henry@uhc.com<mailto:jan_henry@uhc.com>
p. (808) 544.8852
f. (855) 299.1149

From: Bonnie Marsh [mailto:BMarsh@hsag.com]
Sent: Friday, February 07, 2014 4:15 PM
To: Henry, Jan L
Subject: RE: Request for Information by 2/7/14 (UHCCP Hawaii)

Thank you, Jan. This is helpful (and complete). I do have a follow-up question. For the one credentialing standard (CR 3, Element B re work history) that had a finding, while I understand that NCQA did not require corrective action, was there any documented action that the plan took, or evidence of follow-up self-monitoring to ensure this was remedied going forward? I understand that NCQA considers this rating fully compliant for purposes of accreditation, thus you were accredited. So the reason I am asking is that for this step in the

state's quality strategy, any finding of deficiency must be corrected in order to be considered for deemed compliance in the area. Here is the step I am referring to:

Step 3: Health Plan is reviewed by an accrediting organization and achieves full compliance with deemable standards
Requirement: To be considered for deemed compliance, the QUEST or QExA plan must have achieved a favorable rating from the accrediting organization within the previous three year period, and all standards must have been found fully compliant or must have been brought into full compliance through implementation of a CAP within the three year period.

I am preparing a checklist and recommendations for the MQD for it's decision on plans that may be deemed compliant and skip our review of these select standards in May and want to give them this information if there is anything you have by way of documentation. Thoughts?

I know it's late in the day so early next week is fine for a response. Have a great weekend!

Thank you,
Bonnie

From: Henry, Jan L [mailto:jan_henry@uhc.com]
Sent: Friday, February 07, 2014 3:18 PM
To: Bonnie Marsh
Cc: Patricia Bazin (pbazin@medicaid.dhs.state.hi.us<mailto:pbazin@medicaid.dhs.state.hi.us>); Cori Woo (cwoo@medicaid.dhs.state.hi.us<mailto:cwoo@medicaid.dhs.state.hi.us>); Herndon, David R; Nichols, Carol
Subject: Request for Information by 2/7/14 (UHCCP Hawaii)

Bonnie,

Attached is UHCCP's updated Deemed Compliance Info Request, as well as the following supplemental documents:

* NCQA Certification letter
* NCQA Accreditation Certificate
* NCQA Current Status
* NCQA Results Detail screen shots

Please let me know if you need any clarification or additional information.

Best regards,

Jan L. Henry, RN, JD
Compliance Officer
UnitedHealthcare Community Plan
841 Bishop Street, Suite 725
Honolulu, HI 96814
jan_henry@uhc.com<mailto:jan_henry@uhc.com>
p. (808) 544.8852
f. (855) 299.1149

From: Bonnie Marsh [mailto:BMarsh@hsag.com]

Sent: Monday, January 27, 2014 1:30 PM
To: John McComas (jmccomas@alohacarehawaii.org<mailto:jmccomas@alohacarehawaii.org>); Jonathan Cascino (jcascino@alohacare.org<mailto:jcascino@alohacare.org>); Carol Ganiron (carol.ganiron@kp.org<mailto:carol.ganiron@kp.org>); Jessica Gouvea (jessica.m.gouvea@kp.org<mailto:jessica.m.gouvea@kp.org>); Andreas Cravalho; valerie_yamamoto@hmsa.com<mailto:valerie_yamamoto@hmsa.com>; Aubrey Pucan Hester (Aubrey_Pucan_Hester@hmsa.com<mailto:Aubrey_Pucan_Hester@hmsa.com>); Morriarty, Wendy (Wendy.Morriarty@wellcare.com<mailto:Wendy.Morriarty@wellcare.com>); june.mellor@wellcare.com<mailto:june.mellor@wellcare.com>; Herndon, David R; Henry, Jan L
Cc: Patricia Bazin (pbazin@medicaid.dhs.state.hi.us<mailto:pbazin@medicaid.dhs.state.hi.us>); Cori Woo (cwoo@medicaid.dhs.state.hi.us<mailto:cwoo@medicaid.dhs.state.hi.us>)
Subject: Request for Information by 2/7/14
Importance: High

Aloha Hawaii Medicaid Health Plan Compliance Review Contacts!

Please see the attached letter and complete the request for information at your earliest convenience (and by the due date of February 7). I am available for questions should you have any. I will be compiling your information for a decision by the MQD as to "deemability" for each individual health plan as described.

Thanks!
Bonnie

Bonnie Marsh, BSN, MA
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Health Services Advisory Group
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image001.png (119K)
image002.png (58K)

Att. #1

FINDINGS/RECOMMENDATIONS : 2011

FINDINGS	RECOMMENDATIONS
Entities may not be aware of current NCQA standards.	All entities should have access to the most current health plan standards published by the NCQA.
Required elements meet criteria but are not documented due to constraints of the organization.	The entities should consider adopting a separate documentation process to address the operational aspects of credentialing. Currently, the operations are included in documents that require a vote by the medical staff to effect changes.
Based on information provided by HPH-CVS, some required elements for credentialing (e.g. sanction information) are obtained and maintained by the Hawaii Pacific Health corporate office and reports disseminated on a monthly basis to HPH-CVS for use in the credentialing program.	HPH-CVS should develop written policies and procedures to document the process of verifying information from acceptable sources. It was evident from the document/file review that there is compliance with the standards. There is also partial documentation of the process at HPH-CVS. As noted above, it would be beneficial for HPH-CVS to have access to the NCQA standards.
Timeliness of reviews. Some documents were difficult to determine whether it was received within the 180-day time limit.	Documents in the file should be date-stamped electronically or by hand with the date of receipt to ascertain timeliness of review.
Work history/curriculum vitae. The documents were in compliance in identifying gaps of six-months or more. However, some were lacking the month/year format.	The 2011 NCQA standards require that the work history/curriculum vitae be in month/year format and that the staff person reviewing the information sign or initial the document with the date of the review. This may also be accomplished by including the name of the reviewer and the date of review on a checklist.

CONCLUSION:

Att. #2

2012 Annual Delegation Oversight Audit Report

FINDINGS/RECOMMENDATIONS

FINDING	RECOMMENDATION
NCQA Standards	As previously recommended, all entities should be allowed access to the current health plan standards published by the NCQA. This will provide the entities with information that is the basis for our audits. Periodic updates to the standards are posted on the NCQA website.
Documentation of compliance with required elements.	A review of submitted documents indicates compliance with our previous recommendation.
Timeliness of reviews.	The results of the file audits indicate compliance with our previous recommendation.
Physician Assistants Documentation of the physician-sponsor's registration with the State of Hawaii was not included in the PA's file.	Since Hawaii's licensure law requires registration by the physician-sponsor, we strongly recommended including a copy of the verification in the physician assistant's file. This is available via the State's license verification website. (http://pvl.ehawaii.gov/pvlsearch/app)

CONCLUSION: