Attachment A

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

HSAG Health Services Advisory Group

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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.

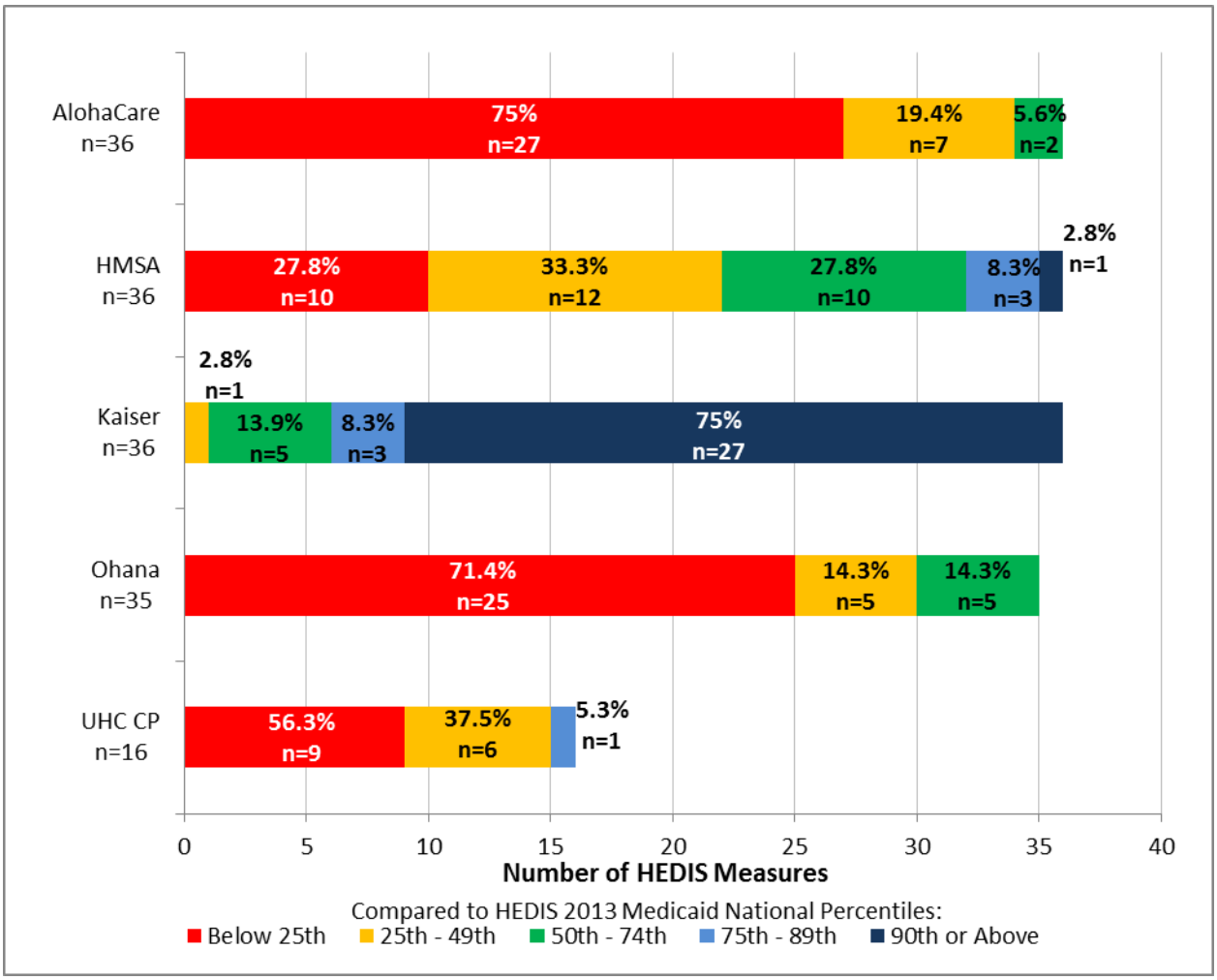
Similarly, for the seven 'Ohana CCS-specific measures that followed HEDIS Medicaid calculation and reporting specifications, HSAG compared the results to the national Medicaid HEDIS 2013 means and percentiles. Figure 1-3 displays the number of CCS indicators that fell within the designated percentile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

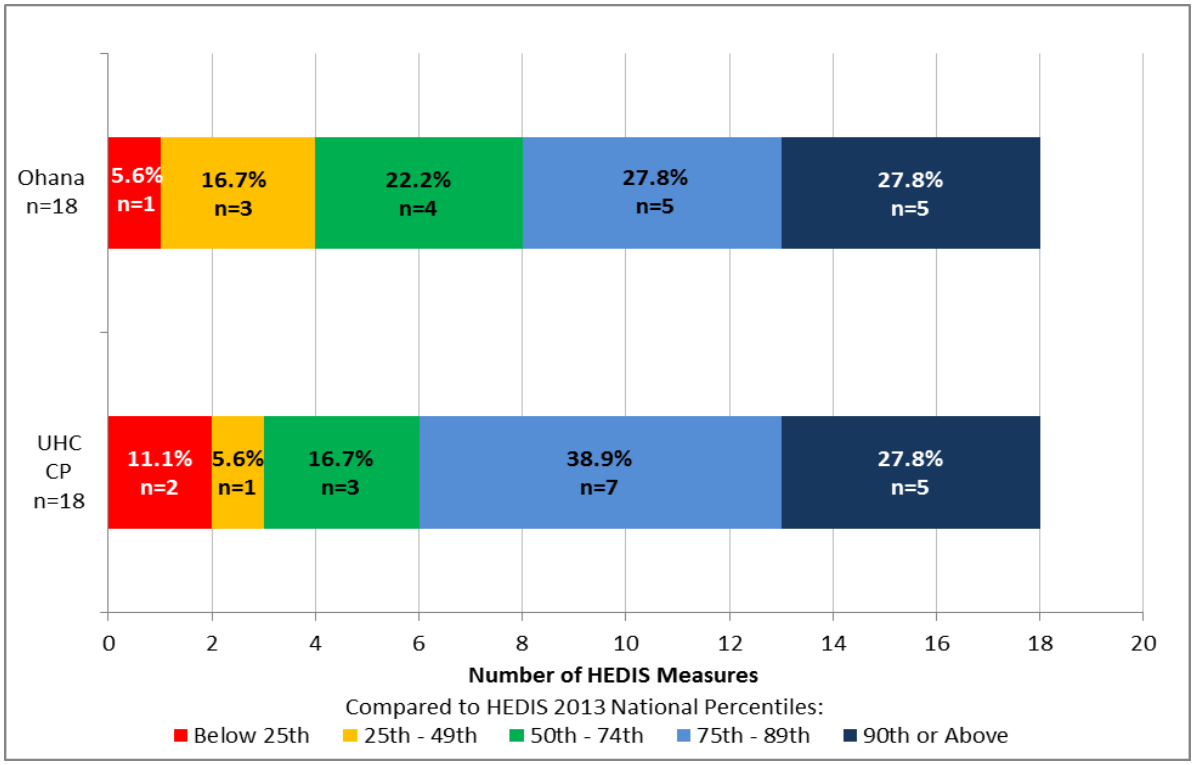
Figure 1-1—Comparison of QUEST Plan Indicators to HEDIS Medicaid National Percentiles



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.

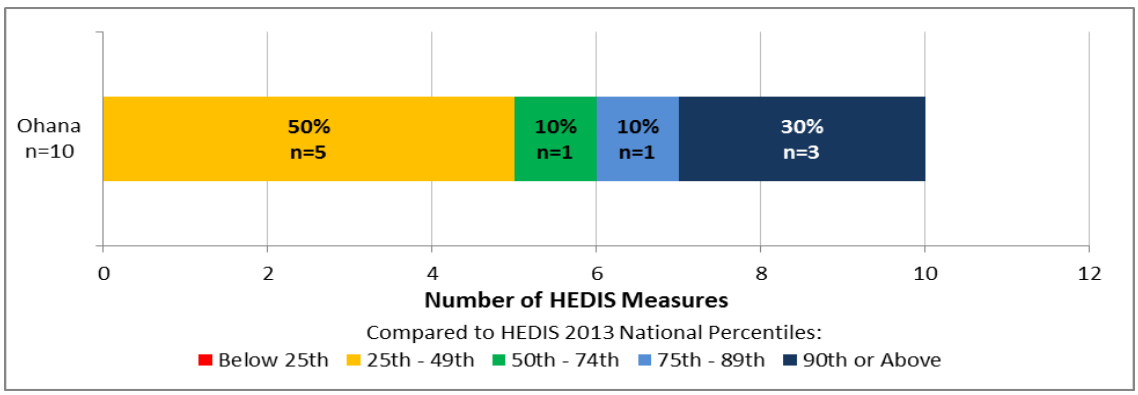
Figure 1-2—Comparison of QExA Plan Indicators to HEDIS Medicaid National Percentiles



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

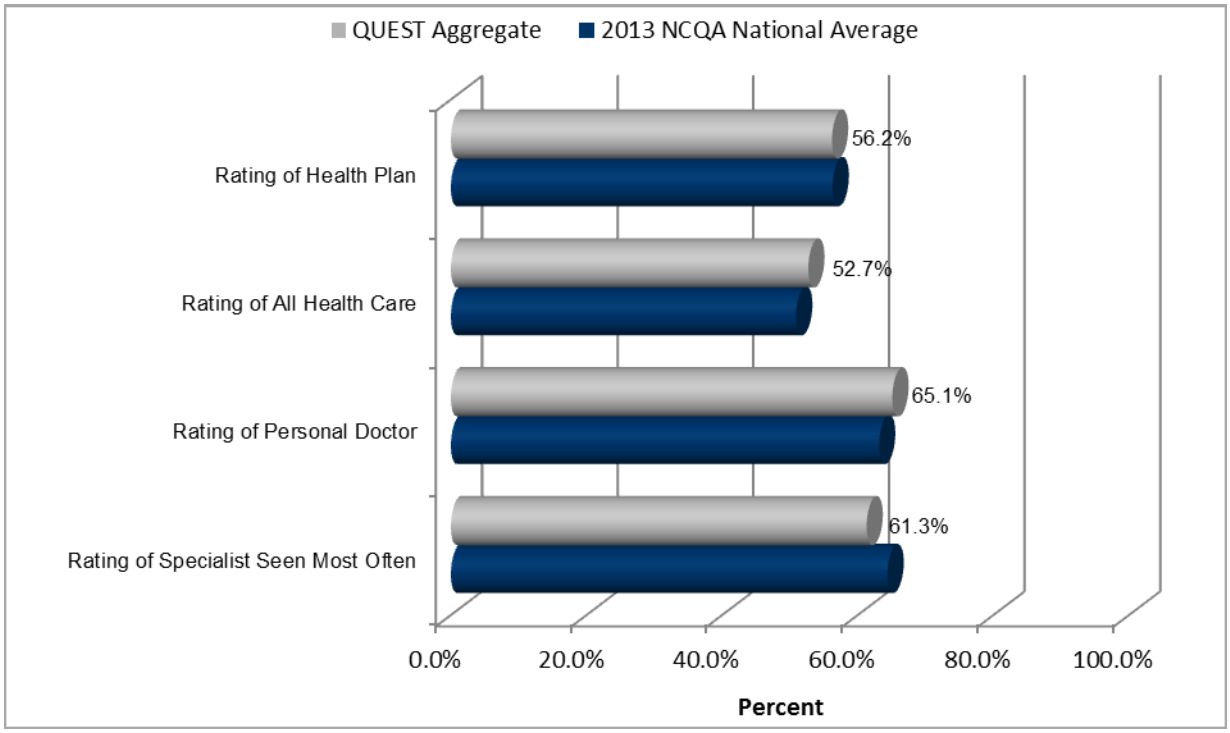
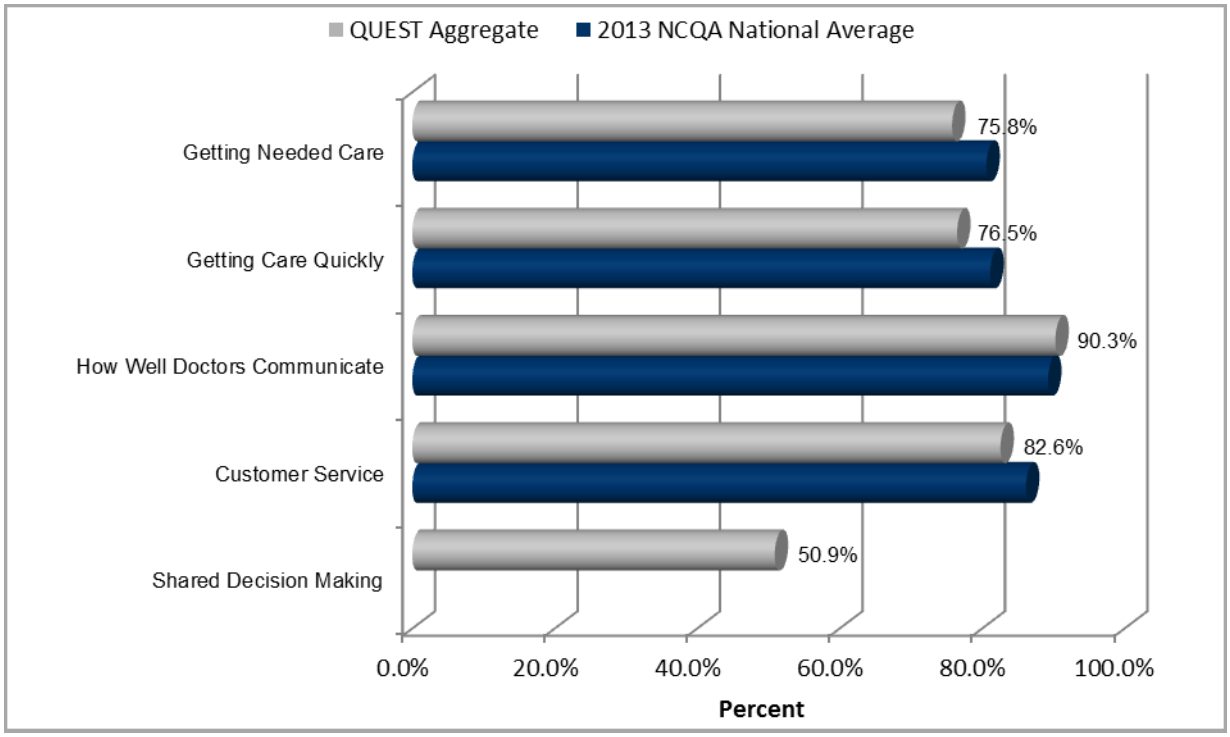


Figure 1-5 depicts the top-box scores for the statewide QUEST aggregate and the 2013 NCQA national adult Medicaid average for each of the composite measures.

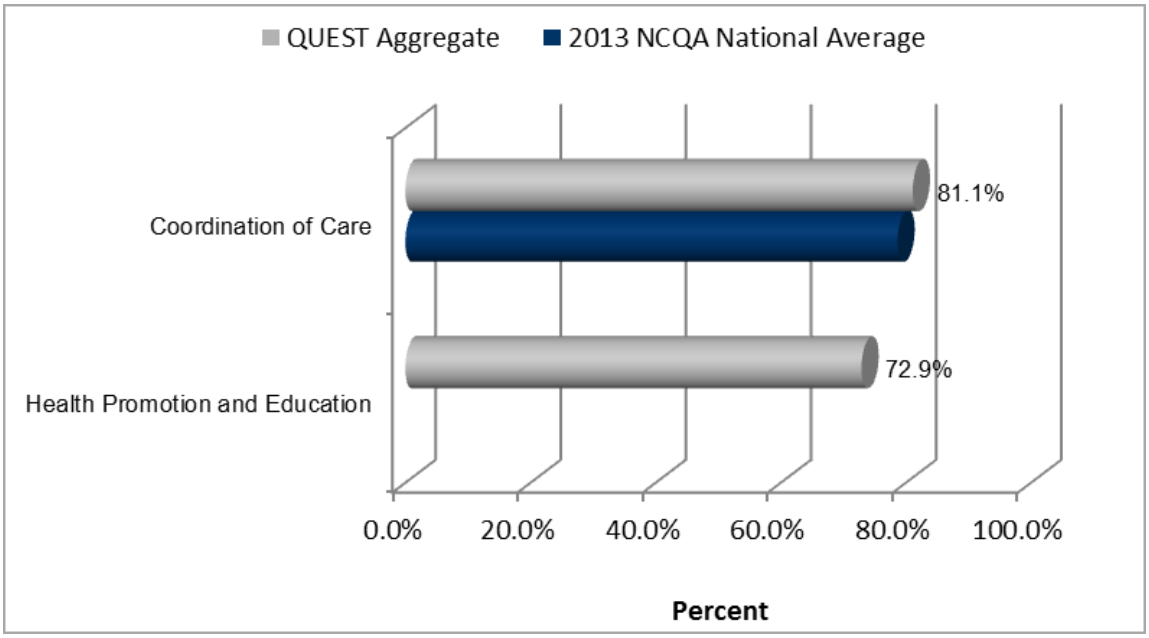
Figure 1-5—QUEST Aggregate: Composite Measures



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

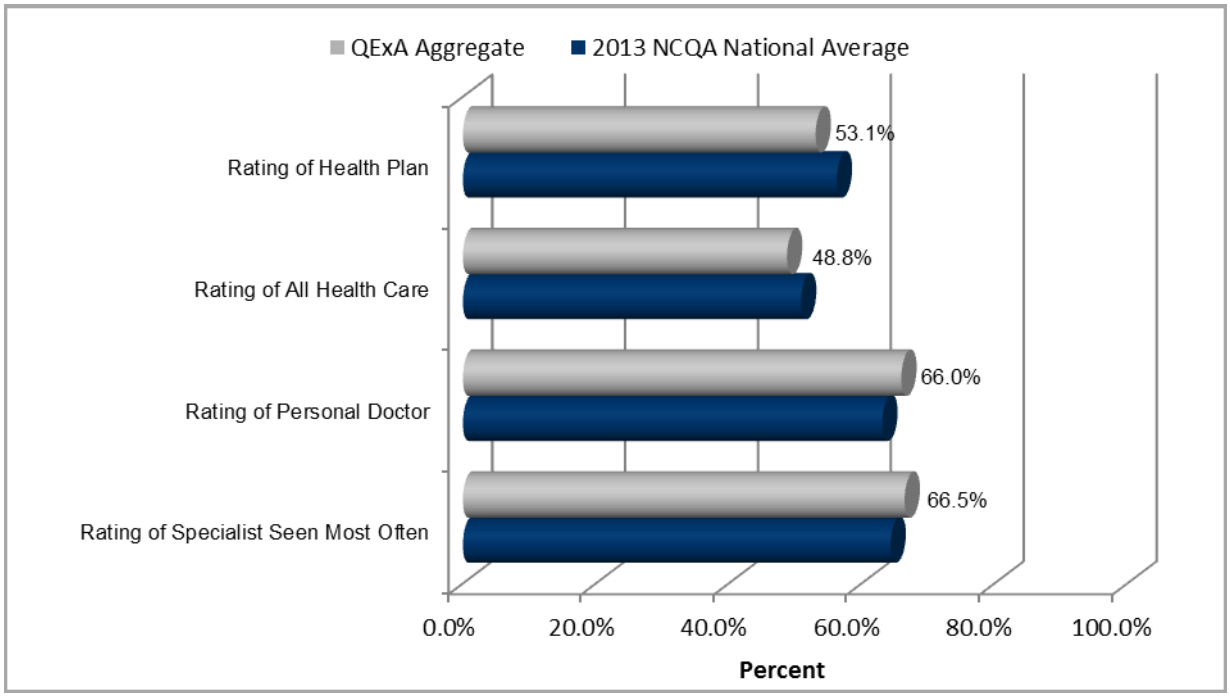
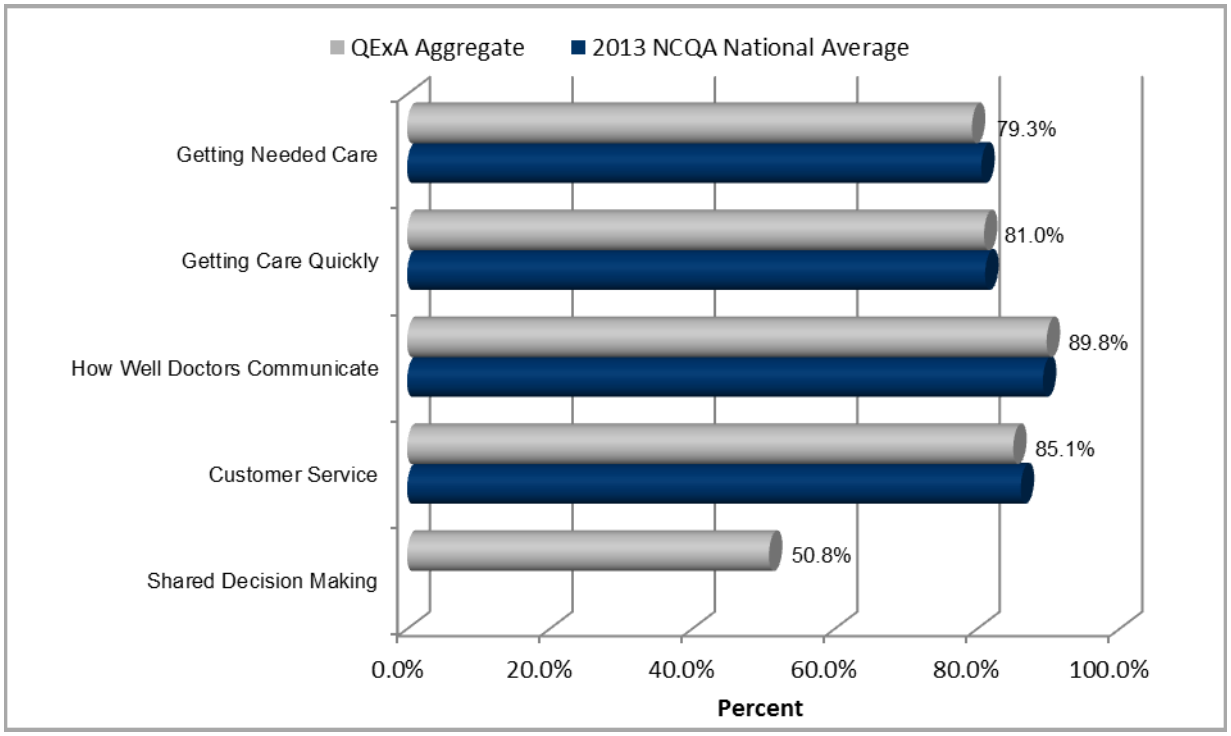


Figure 1-8 depicts the top-box scores for the statewide QExA aggregate and the 2013 NCQA national adult Medicaid average for each of the composite measures.

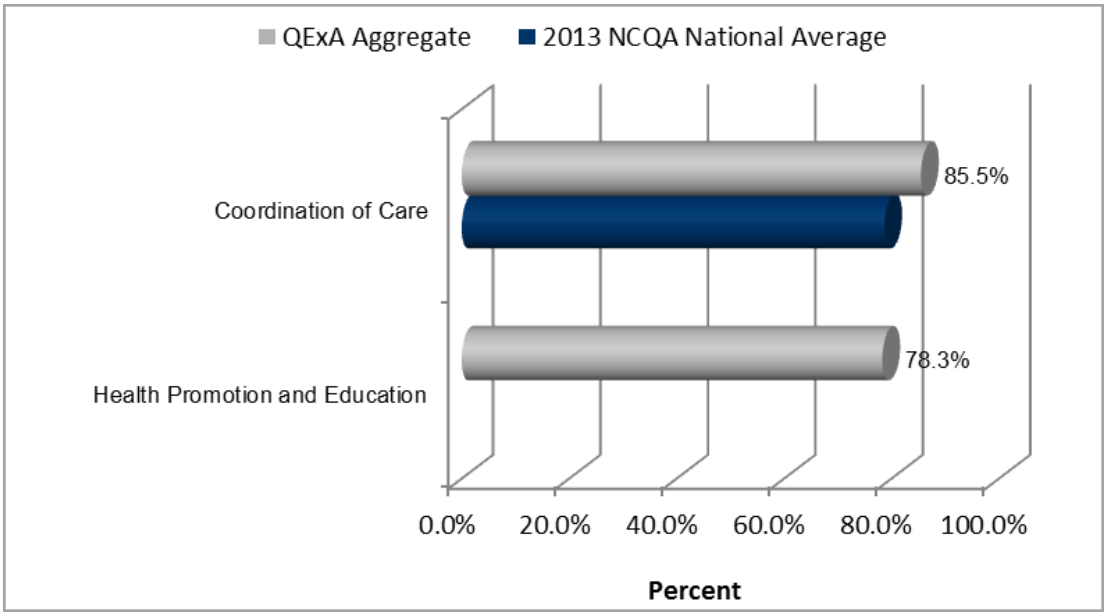
Figure 1-8—QExA Aggregate: Composite Measures



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

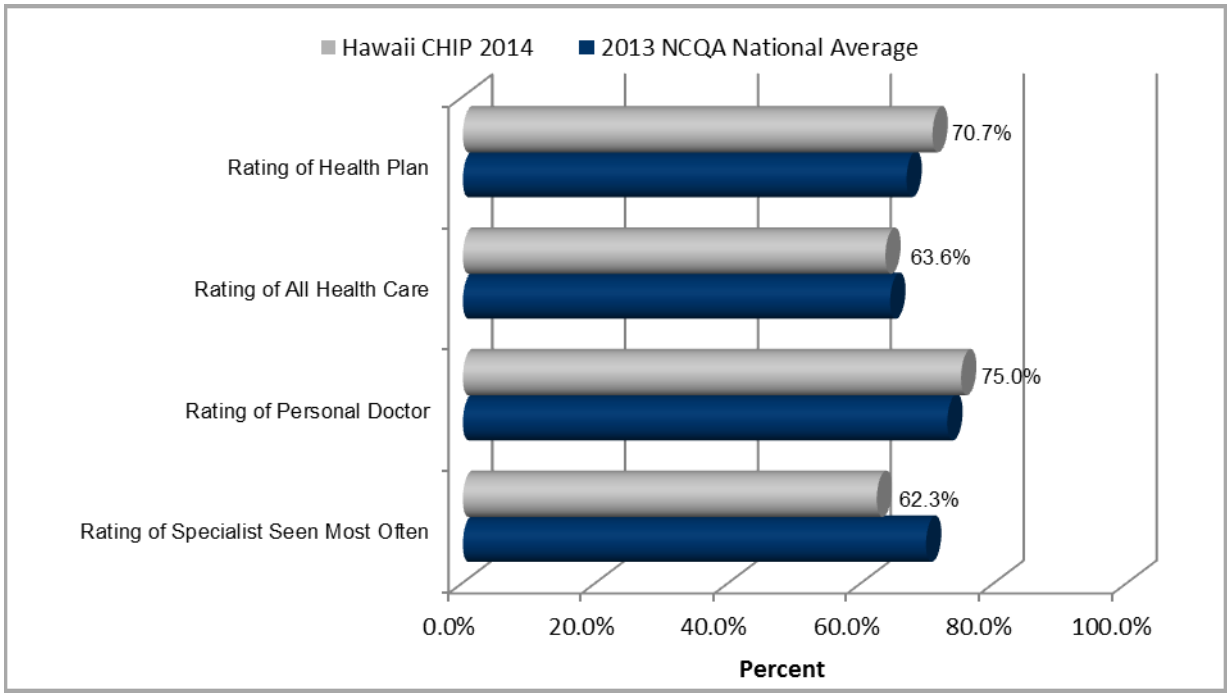
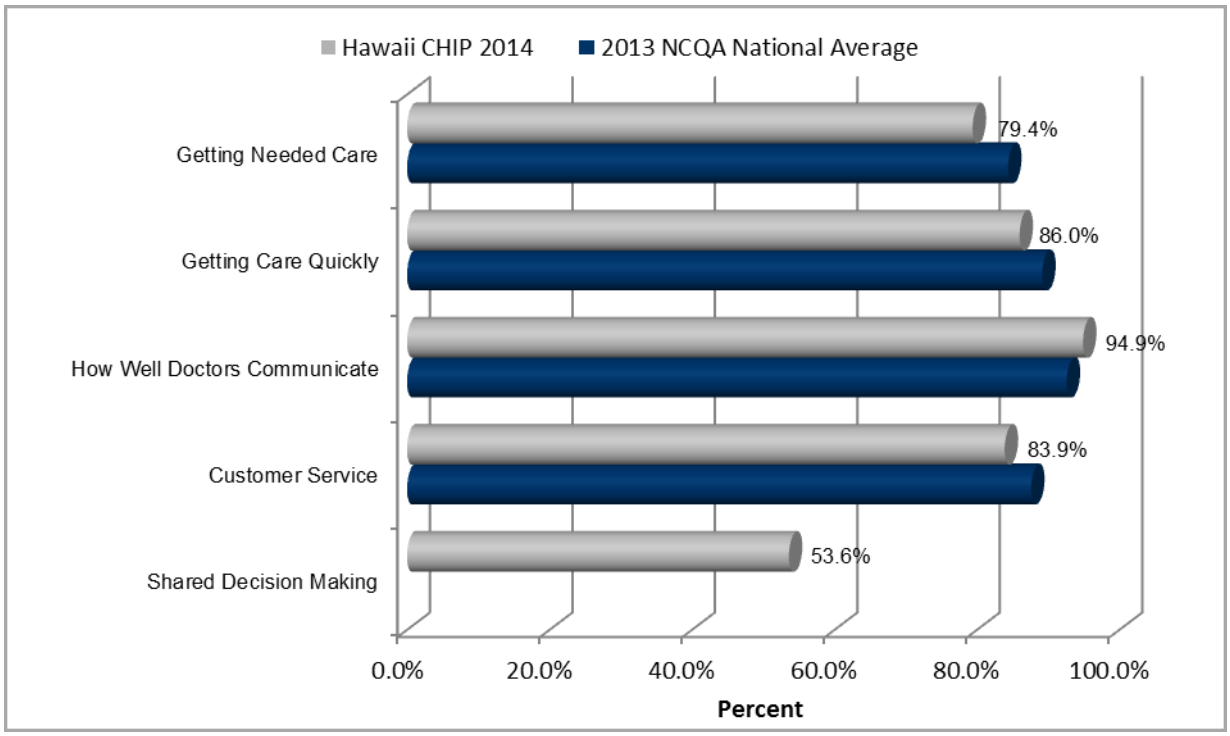


Figure 1-11 depicts the top-box scores for CHIP and the 2013 NCQA national child Medicaid average for each of the composite measures.

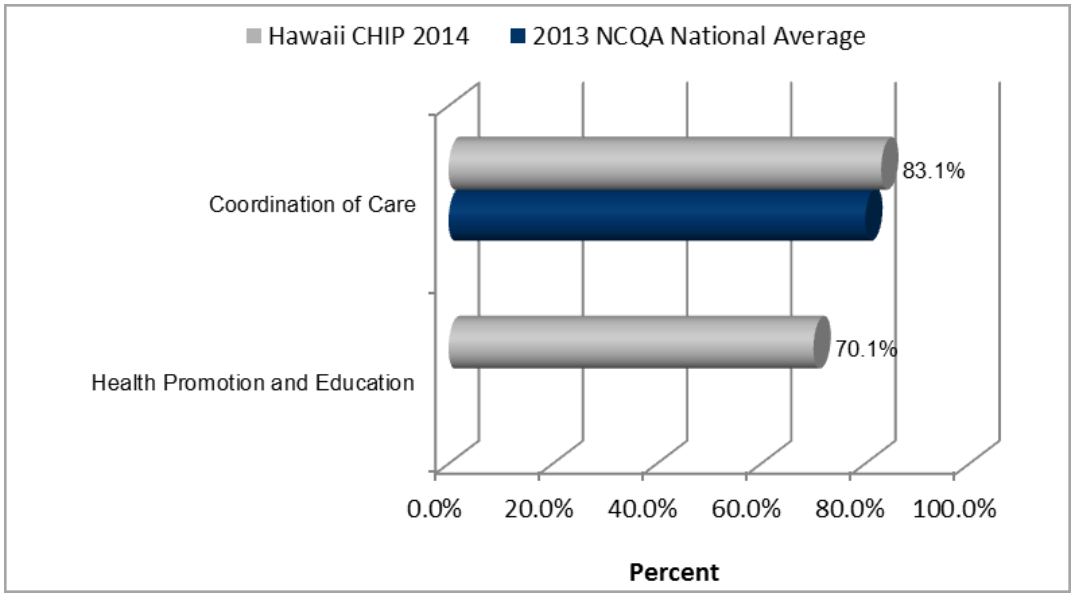
Figure 1-11—CHIP: Composite Measures



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



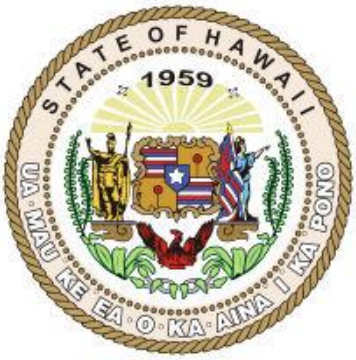
Please note: Due to changes to the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

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

State of Hawaii

Department of Human Services

Med-QUEST Division



2015 External Quality Review Report of Results *for the* QUEST Integration Health Plans and the Community Care Services Program

November 2015

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Overview

The 2015 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) 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 QI health plans and the CCS program. The QI health plans were AlohaCare QUEST Integration Plan (AlohaCare), Hawaii Medical Service Association QUEST Integration Plan (HMSA), Kaiser Permanente Hawaii QUEST Integration Plan (Kaiser), 'Ohana Health Plan QUEST Integration ('Ohana), and UnitedHealthcare Community Plan QUEST Integration (UHC CP). 'Ohana also has held the contract for the Community Care Services (CCS) program since March 2013. CCS is a carved-out behavioral health specialty services plan for individuals who have been determined by the MQD to have a serious mental illness.

According to the federal Medicaid managed care regulations (42 CFR 438), the QI 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, however, the Hawaii MCOs and PIHP will be referred to collectively 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—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). Two optional EQR activities were also performed this year: Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] surveys of Medicaid child members and Children's Health Insurance Program (CHIP) members using the CAHPS 5.0H Child Medicaid CAHPS survey instruments. While the child Medicaid 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.

This report includes the following for each EQR activity conducted:

- Objectives

[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).

- 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, healthcare services provided by each health plan.

This is the eleventh 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 the 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 QI and CCS health plans.

Compliance Monitoring Review of Standards

Description

For the 2015 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the CCS program, using monitoring tools to assess and document compliance with a set of federal and State requirements. This review brought the CCS program into alignment with the review schedule for the QI plans to ensure all standards were reviewed within a three-year period for all health plans. The standards selected for review were related to the CCS program's State contract requirements and the federal Medicaid managed care regulations in the Code of Federal Regulations (CFR) for five areas of review, or standards. A pre-on-site desk review and an on-site review with interview sessions and record reviews were conducted.

The second compliance review activity in 2015 involved HSAG's and the MQD's follow-up monitoring of the three health plans that were required to take corrective actions related to findings from HSAG's 2014 compliance review, and the follow-up monitoring of CCS' corrective actions related to its 2015 compliance review.

Findings, Conclusions, and Recommendations

For the compliance review of CCS, the following table illustrates the CCS program's performance in each of the standard areas reviewed. For comparison purposes, the statewide average score for the QI health plans is also presented, based on HSAG's review of these same standards in 2013.

Table 1-1—Compliance Standards and Scores			
Standard #	Standard Name	2015 ʻOhana CCS	2013 Statewide All Plans
I	Member Rights and Protections and Member Information	**100%**	**92%**
II	Member Grievance System	**89%**	**90%**
III	Access and Availability	**100%**	**98%**
IV	Coverage and Authorization	**94%**	**94%**
V	Coordination and Continuity of Care	**100%**	**99%**
	Total Compliance Score:	**95%**	**93%**

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.

CCS' performance across all standards was strong, with three standard areas achieving 100 percent (Member Rights and Protections and Member Information, Access and Availability, and Coordination and Continuity of Care) and only one standard area (Member Grievance System) scoring slightly below 90 percent. CCS' overall score of 95 percent exceeded the health plans' statewide score from HSAG's review of the same standards in 2013 (93 percent).

CCS was required to develop a corrective action plan (CAP) to address and resolve deficiencies identified in the review. HSAG and the MQD provided follow-up monitoring. ʻOhana CCS completed all of the CAP activities as planned and was found to be in full compliance with the standards by July 2015.

The QI health plans' CAP implementation resulting from HSAG's 2014 compliance review was also monitored by HSAG and the MQD. AlohaCare, Kaiser, and ʻOhana health plans had continuing corrective actions implemented in 2015, mostly related to policies, procedures, forms, and required reporting to the MQD of the plans' provider disclosure information. The compliance review CAPs were closed out as completed in July 2015; however, the MQD continued its oversight and monitoring to ensure timely and complete capture and reporting of the provider disclosure information required under 42 CFR 455.

With the completion of these reviews, the health plans and CCS have demonstrated their structural and operational compliance and ability to provide quality, timely, and accessible services. Calendar year 2016 will begin a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program.

Validation of Performance Measures—HEDIS Compliance Audits

Description

HSAG performed independent audits of the performance measure data calculated by the QUEST, QExA, and CCS health plans according to the *2015 NCQA HEDIS Compliance Audit*[1-3] *Standards, Policies, and Procedures, HEDIS Volume 5*. The audit procedures were also consistent with the CMS protocol for performance measure validation: *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-4] The health plans that contracted with MQD during the measurement year (2014) for either the QUEST or QUEST Expanded Access (QExA) programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each NCQA 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. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting 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 or non-HEDIS performance measures. The health plans with populations other than aged, blind, or disabled (ABD) populations were required to report on 33 measures. Health plans with ABD populations were required to report on 36 measures. CCS was required to report on nine HEDIS measures and two non-HEDIS measures. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality and timeliness of, and access to, Medicaid care and services. These domains included:

- Children's Preventive Care
- Women's Health
- Care for Chronic Conditions
- Access to Care
- Utilization
- Effectiveness of Care

The measurement period was calendar year (CY) 2014 (January 1, 2014, through December 31, 2014), and the audit activities were conducted concurrently with HEDIS 2015 reporting. All five former QUEST plans (AlohaCare, HMSA, Kaiser, 'Ohana, and UHC CP) were required to report the non-ABD measures. The two former QExA health plans ('Ohana and UHC CP) were required to report the ABD measures. In addition, 'Ohana was required to report rates for the CCS-specific measures.

[1-3] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).
[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2015.

Findings, Conclusions, and Recommendations

HSAG evaluated each health plan's compliance with the National Committee for Quality Assurance's (NCQA's) IS standards. All health plans but one (AlohaCare) were fully compliant with all standards and able to report valid performance measure rates. AlohaCare did not capture all the data elements required for certain measures in one of its supplemental databases and therefore was found substantially compliant with IS 5.0 (Supplemental Data—Capture, Transfer and Entry). Nonetheless, since the plan could still use medical record abstracted data to report the measures, the impact of having this database disapproved for reporting was mitigated. AlohaCare was, therefore, still able to report valid performance measure rates.

All plans except Kaiser used software vendors that participated in NCQA's measure certification program. All HEDIS measures generated by these vendors and required by MQD for reporting were certified by NCQA. Kaiser calculated the required measures using internally developed programming code. All plans used supplemental 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 NCQA national Medicaid HEDIS 2014 means and percentiles. For the inverse measure indicators, where a lower rate indicates better performance (i.e., *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*, *Well-Child Visits in the First 15 Months of Life—0 Visits*, *Plan All-Cause Readmissions*, *Frequency of Prenatal Care—<21 Percent*, and *Ambulatory Care—ED Visits/1,000)*, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied.[1-5]

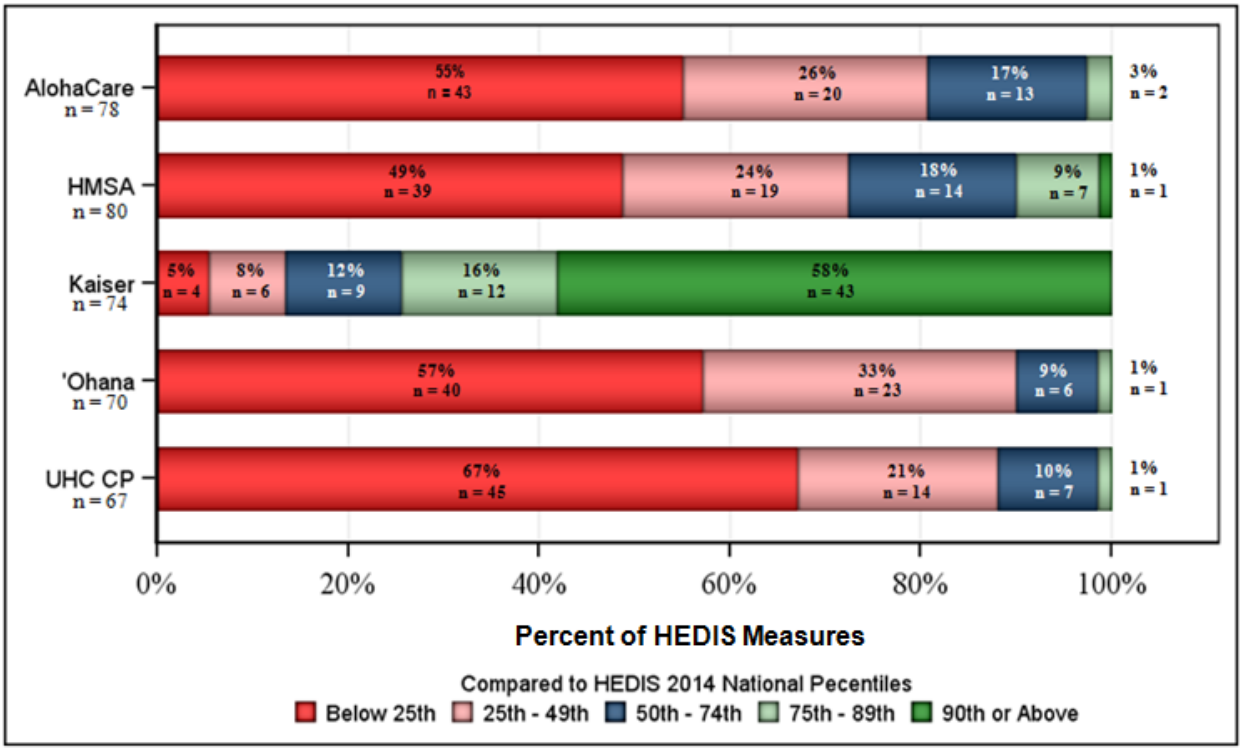
The "n" in the following figures indicates, by health plan, the number of indicators in the non-ABD, ABD, and CCS performance measures that fell within the designated percentile range compared to the HEDIS 2014 national Medicaid percentiles. Rates representing a population too small for reporting purposes were referred to as "*Not Applicable*," or *NA*, and were not included in the performance calculations.

HSAG validated 33 HEDIS 2015 non-ABD performance measures, resulting in a total of 103 separate indicator rates reported across all audited measures, of which 81 indicators were compared to national Medicaid HEDIS 2014 percentiles.[1-6] None of the plans reported all 81 indicators. AlohaCare had three indicators, HMSA had one indicator, Kaiser had seven indicators, 'Ohana had 11 indicators, and UHC CP had 14 indicators with denominator(s) less than 30 for which valid rates could not be reported. For those indicators, the plans received an audit result of *NA* (small denominator). Figure 1-1 shows the plans' performance on the non-ABD population measure indicators compared to the national percentiles.

[1-5] 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.

[1-6] The *Enrollment by Product Line*, *Inpatient Utilization-General Hospital/Acute Care*, and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, Medicaid national percentiles do not exist for *Plan All-Cause Readmissions* and *Colorectal Cancer Screening*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

Figure 1-1—Comparison of Non-ABD Measure Indicators to HEDIS Medicaid National Percentiles

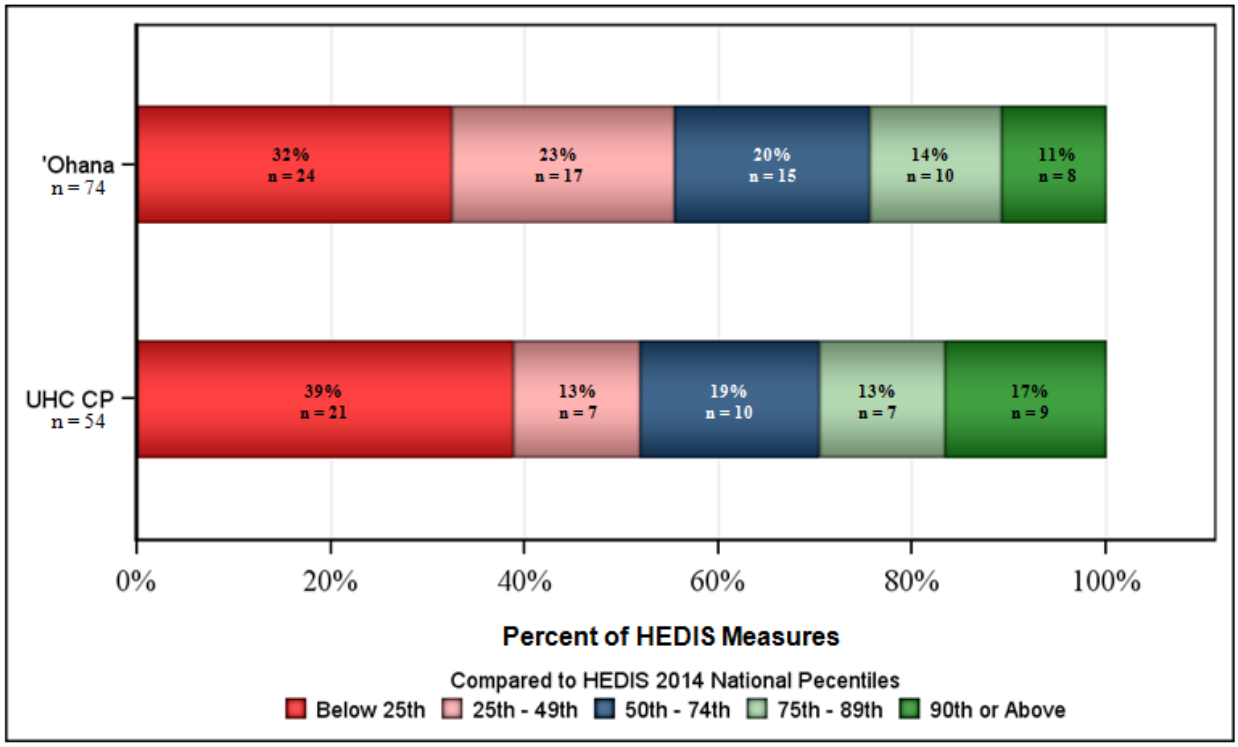


Please note: Percentages may not total 100% due to rounding.

As presented in Figure 1-1, the plans were diverse in their performance. Kaiser, the best-performing plan for HEDIS 2015, reported 58 percent of its indicators (43 of 74) at or above the HEDIS 2014 national Medicaid 90th percentile, along with 16 percent of its indicators (12 of 74) reporting at or above the national 75th percentile but below the 90th percentile. HMSA reported 22 out of 80 rates above the 50th percentile, including eight rates above the 75th percentile and one rate above the 90th percentile. AlohaCare, 'Ohana, and UHC CP were the lowest-performing plans compared to the national percentiles, reporting at least 55 percent of their measures with valid rates below the national 25th percentile. HMSA had eight measures above the national 75th percentile. While AlohaCare had two rates above the national 75th percentile, UHC CP and 'Ohana only had one rate above the national 75th percentile.

HSAG validated 36 HEDIS 2015 ABD population performance measures for the two former QExA health plans, resulting in a total of 106 separate indicator rates reported across all audited measures, of which 82 indicators were compared to national Medicaid HEDIS 2014 percentiles.[1-7] Neither of the plans reported all 82 indicators. 'Ohana had eight indicators and UHC CP had 28 indicators with denominators less than 30 (and for which a valid rate could not be reported). For those indicators, the two plans received an audit result of *NA* (small denominator). Figure 1-2 shows the plans' performance on the ABD population measures compared with the national percentiles.

Figure 1-2—Comparison of ABD Measure Indicators to HEDIS Medicaid National Percentiles



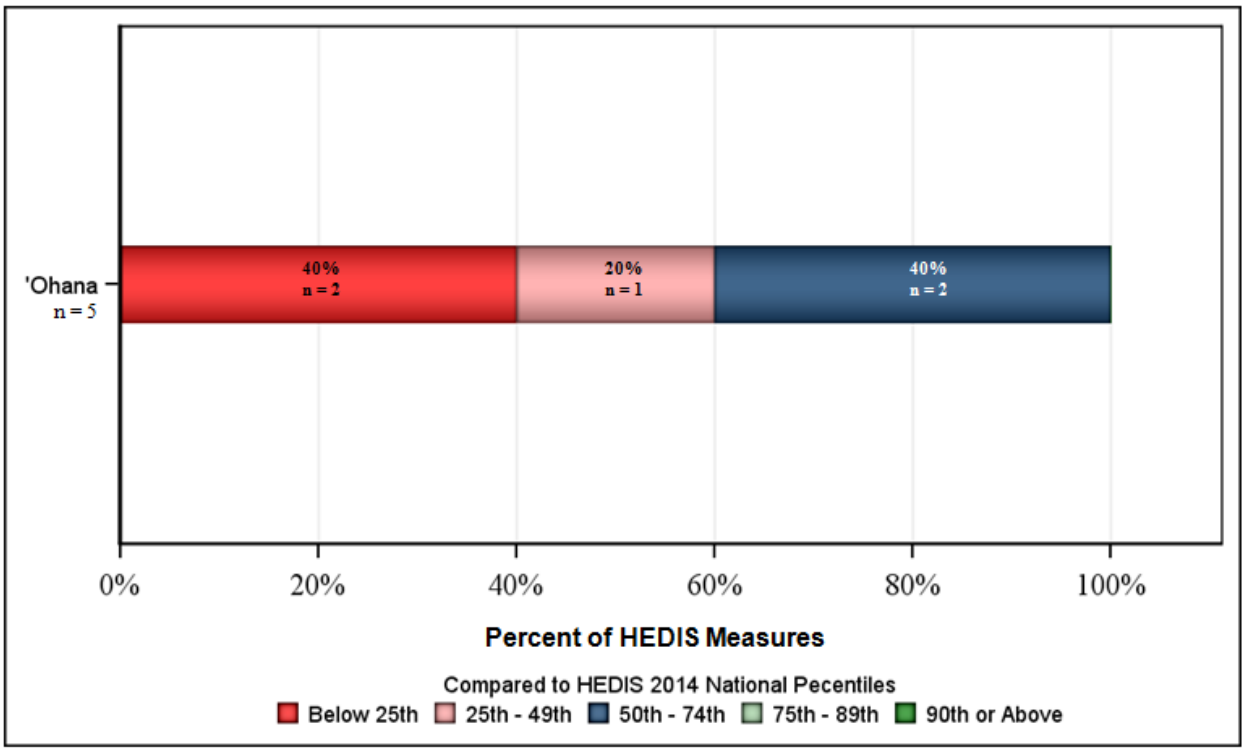
Please note: Percentages may not total 100% due to rounding.

As presented in Figure 1-2, performance between the two plans varied slightly. UHC CP was the better-performing plan, with 26 of the 54 rates with available benchmarks for comparison (or 48 percent) at or above the national 50th percentile. 'Ohana reported 33 of the 74 indicators (or 45 percent) at or above the national 50th percentile.

[1-7] The *Enrollment by Product Line*, *Inpatient Utilization—General Hospital/Acute Care*, and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, Medicaid national percentiles do not exist for *Plan All-Cause Readmissions*, *Care for Older Adults*, *Colorectal Cancer Screening*, and *Medication Reconciliation Post-Discharge*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

HSAG validated nine HEDIS 2015 and two non-HEDIS performance measures for the ‘Ohana CCS program. These performance measures resulted in 20 indicator rates, of which eight indicators were compared to national Medicaid HEDIS 2014 percentiles.[1-8] ‘Ohana CCS received an audit result of *NA* (small denominator) for three indicators. Figure 1-3 shows the CCS performance compared with the national percentiles.

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



As presented in Figure 1-3, ‘Ohana CCS program’s performance was below average for HEDIS 2015. Sixty percent of the HEDIS indicators with available benchmarks for comparison ranked below the national 50th percentile. The remaining 40 percent of the indicators fell at or above the national 50th percentile but below the 75th percentile.

Recommendations for improvement are presented in the plan-specific results sections of this report. In general, HSAG recommends that each plan target the lower-performing measures/indicators for improvement for its respective populations. Each plan should conduct a barrier analysis to determine why performance was low, coupled with data analysis and drill-down evaluations of noncompliant cases.

[1-8] The *Enrollment by Product Line* and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, Medicaid national percentiles do not exist for *Plan All-Cause Readmissions*, and the two non-HEDIS measures: *Behavioral Health Assessment* and *Follow-up with Assigned PCP Following Hospitalization for Mental Illness.* For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

Validation of Performance Improvement Projects (PIPs)

Description

PIPs are designed as an organized way to assist health plans in assessing their healthcare processes, implementing process improvements, and improving outcomes of care. In 2015, HSAG validated two PIPs for each of the QUEST Integration and CCS health plans, for a total of 12 PIPs. The five QUEST Integration plans were required by the MQD to conduct PIPs related to *All-Cause Readmissions* and a second topic to improve *Diabetes Care*. CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*.

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the health plan with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings.

In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement.[1-9] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The new methodology focuses on evaluating and refining small process changes in order to determine the most effective strategies for achieving real improvement.

The key concepts of the new PIP framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.

For this new PIP framework, HSAG developed five modules, each with a companion guide. Each module includes validation criteria necessary for successful completion of a valid PIP. Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

- *High confidence* = the PIP was methodologically sound, achieved meaningful improvement for the SMART (specific, measureable, achievable, relevant, and time-bound) Aim measure, and the demonstrated improvement was clearly linked to the quality improvement processes conducted.
- *Confidence* = the PIP was methodologically sound; achieved meaningful improvement for the SMART Aim measure; and some of the quality improvement processes were clearly linked to the demonstrated improvement, but there was not a clear link between all quality improvement processes and the demonstrated improvement.

[1-9] Institute for Healthcare Improvement. How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: September 24, 2015.

- *Low confidence* = (1) the PIP was methodologically sound, but improvement was not achieved for the SMART Aim measure; or (2) improvement was achieved for the SMART Aim measure, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Findings, Conclusions, and Recommendations

Following the review and validation of the health plans' 2015 PIPs, HSAG concluded that:

- The 2015 PIP validation was a transition year with the health plans moving from submitting PIP Summary Forms with 10 activities to HSAG's rapid-cycle PIP process with five modules.
- The health plans had not yet progressed to reporting healthcare measure outcomes at the time of the validation.
- The performance on the PIPs suggests that the health plans were able to successfully complete Modules 1 through 3 (PIP Initiation, SMART Aim Data Collection, and Intervention Determination) for each PIP topic after receiving feedback and technical assistance from HSAG.
- The PIPs included methodologies that used quality improvement science and were appropriate to measure and monitor outcomes using HSAG's rapid-cycle process.
- Starting in August 2015, the health plans began implementing and testing interventions. Module 4 (Plan-Do-Study-Act) will be submitted for each intervention tested after the results have been obtained.
- Module 5 (PIP Conclusions) will be submitted within a few weeks of the SMART Aim end date.
- The health plans should request technical assistance from HSAG at any point in the process, if needed.

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

Description

The CAHPS health plan surveys are standardized survey instruments which measure members' satisfaction levels with their healthcare. For 2015, HSAG administered the CAHPS 5.0H Child Medicaid Health Plan Survey (without the Children with Chronic Condition [CCC] measurement set), to Medicaid members of the QI health plans, including CHIP-eligible enrollees via a statewide sampling methodology, who met age and enrollment criteria. All parents or caretakers of sampled child Medicaid and CHIP members completed the surveys from February to May 2015 and received an English version of the survey with the option to complete the survey in one of four non-English prevalent languages: Chinese, Ilocano, Korean, or Vietnamese. 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 QI health plans and the statewide QI Program aggregate scores as compared to the 2014 NCQA national child Medicaid average, the following results were noted:[1-10]

- The QI Program aggregate scores were above the NCQA national child Medicaid average on five of the 10 comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Coordination of Care*, and *Health Promotion and Education*.
- AlohaCare QI scored above the NCQA national child Medicaid average on five of the 10 comparable measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, *Coordination of Care*, and *Health Promotion and Education*.
- HMSA QI scored above the NCQA national adult Medicaid average on seven of the 10 comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.
- Kaiser QI scored above the NCQA national child Medicaid average on nine of the 10 comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Coordination of Care*, and *Health Promotion and Education*.
- 'Ohana QI scored above the NCQA national child Medicaid average on one of the 10 comparable measures: *Health Promotion and Education.*
- UHC CP QI scored above the NCQA national child Medicaid average on five of the 10 comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Coordination of Care*, and *Health Promotion and Education.*

Figure 1-4 depicts the top-box scores for the statewide QI Program aggregate and the 2014 NCQA national child Medicaid average for each of the global ratings.

[1-10] Due to changes to the *Shared Decision Making* composite measure, comparisons to 2014 NCQA national averages could not be performed for 2015.

Figure 1-4—QI Program Aggregate: Global Ratings

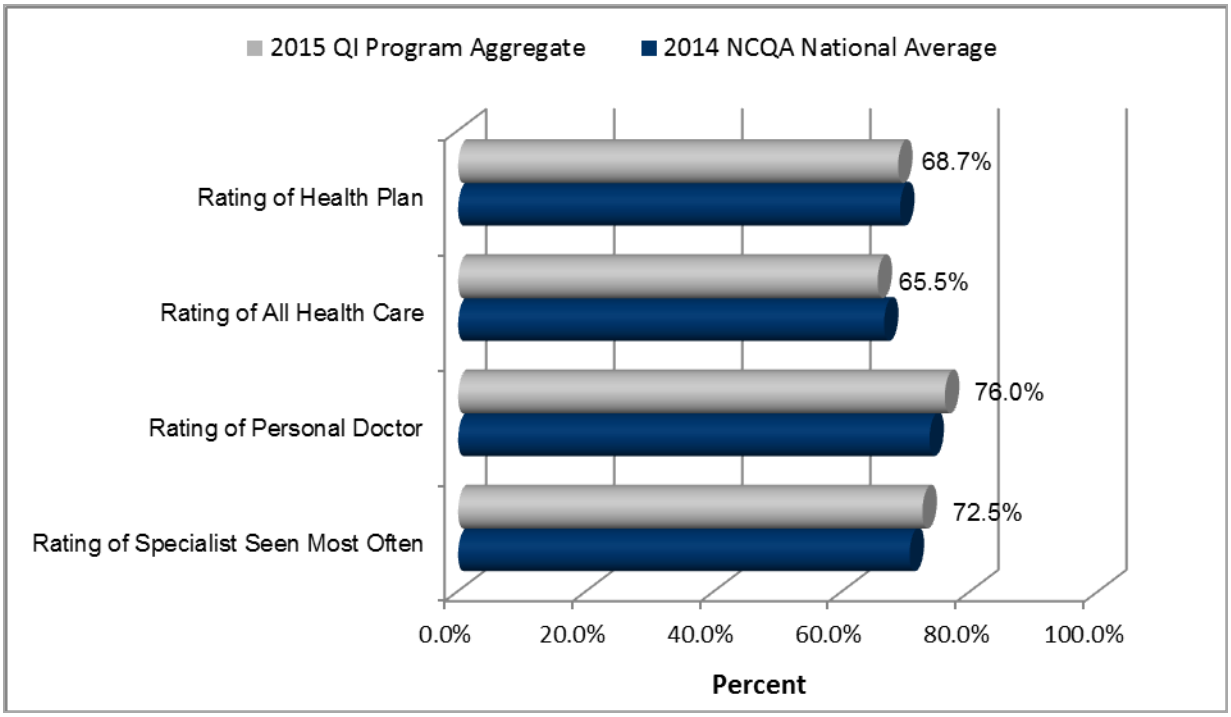
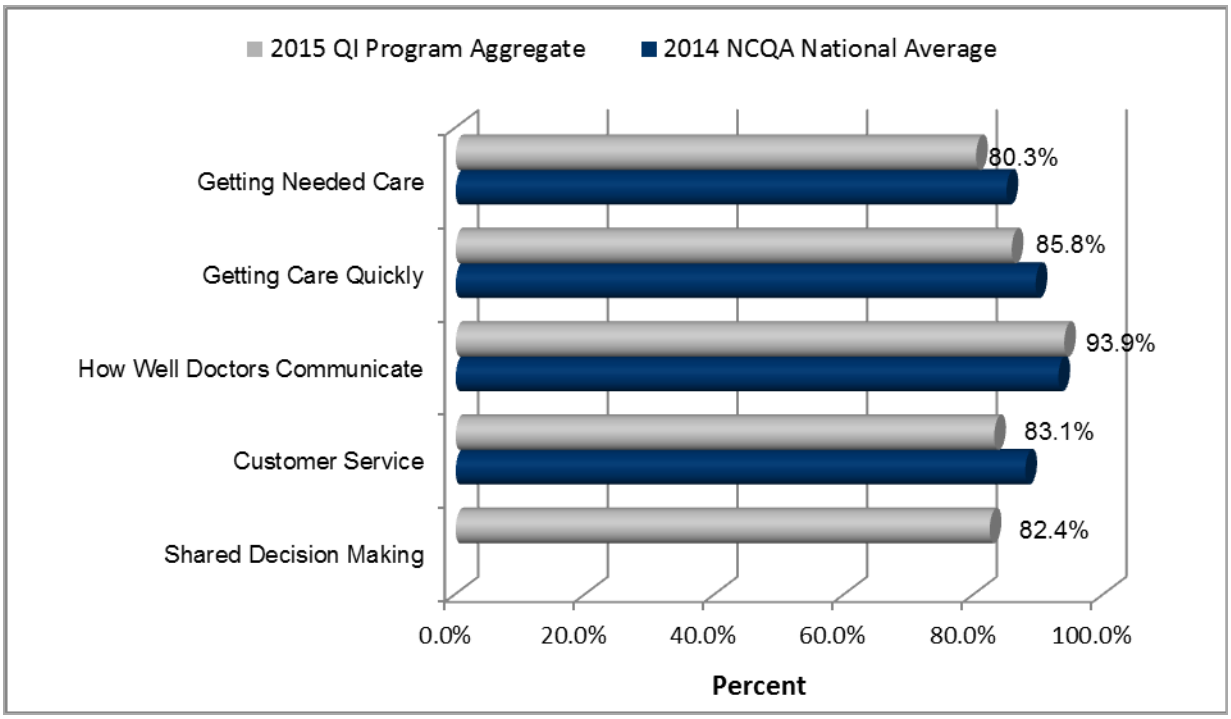


Figure 1-5 depicts the top-box scores for the statewide QI Program aggregate and the 2014 NCQA national child Medicaid average for each of the composite measures.

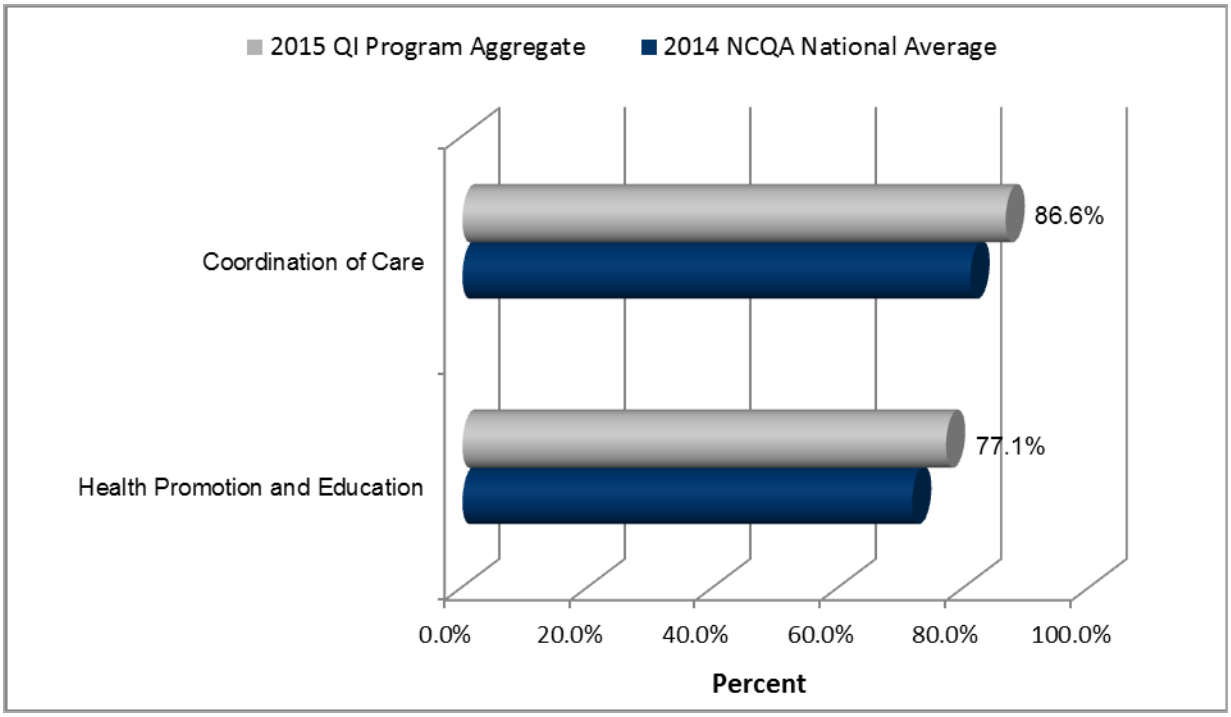
Figure 1-5—QI Program Aggregate: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.

Figure 1-6 depicts the top-box scores for the statewide QI Program aggregate and the 2014 NCQA national child Medicaid average for each of the individual item measures.

Figure 1-6—QI Program Aggregate: Individual Item Measures

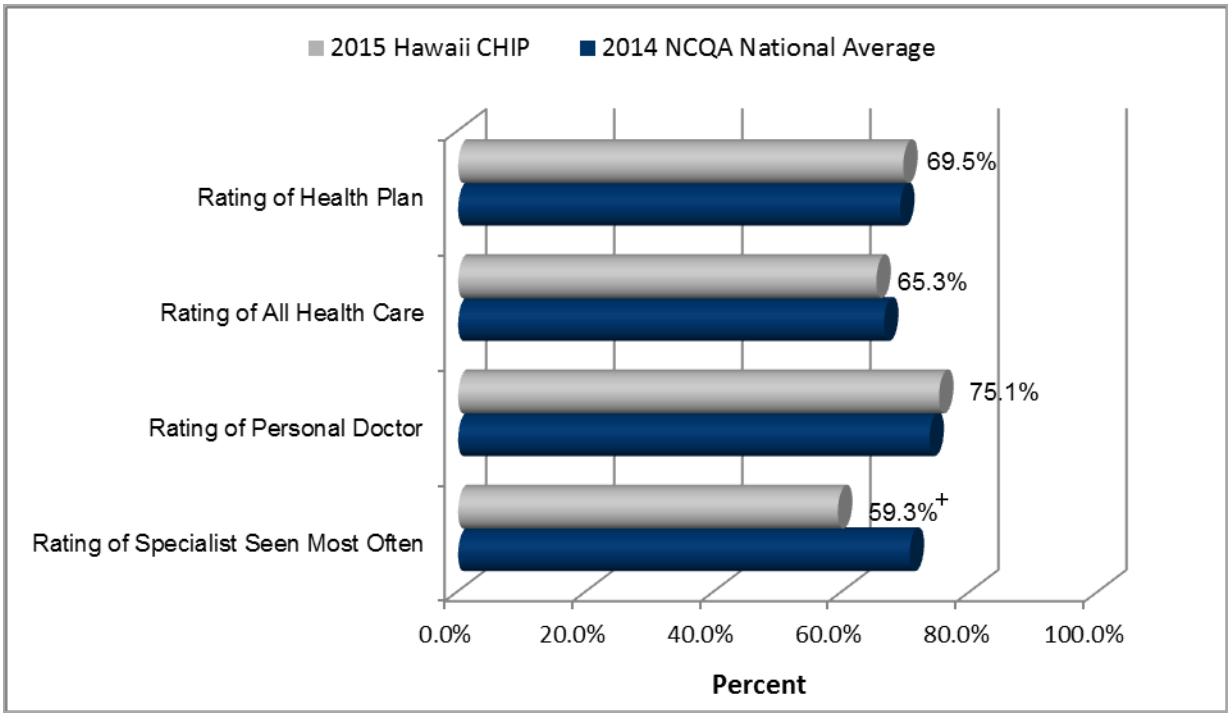


As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparative purposes. As compared to the 2014 NCQA national child Medicaid average, the following results were noted for the CHIP population:

- CHIP scored above the NCQA national child Medicaid average on five of the 10 comparable measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, *Coordination of Care*, and *Health Promotion and Education.*

Figure 1-7 depicts the top-box scores for CHIP and the 2014 NCQA national child Medicaid average for each of the global ratings.

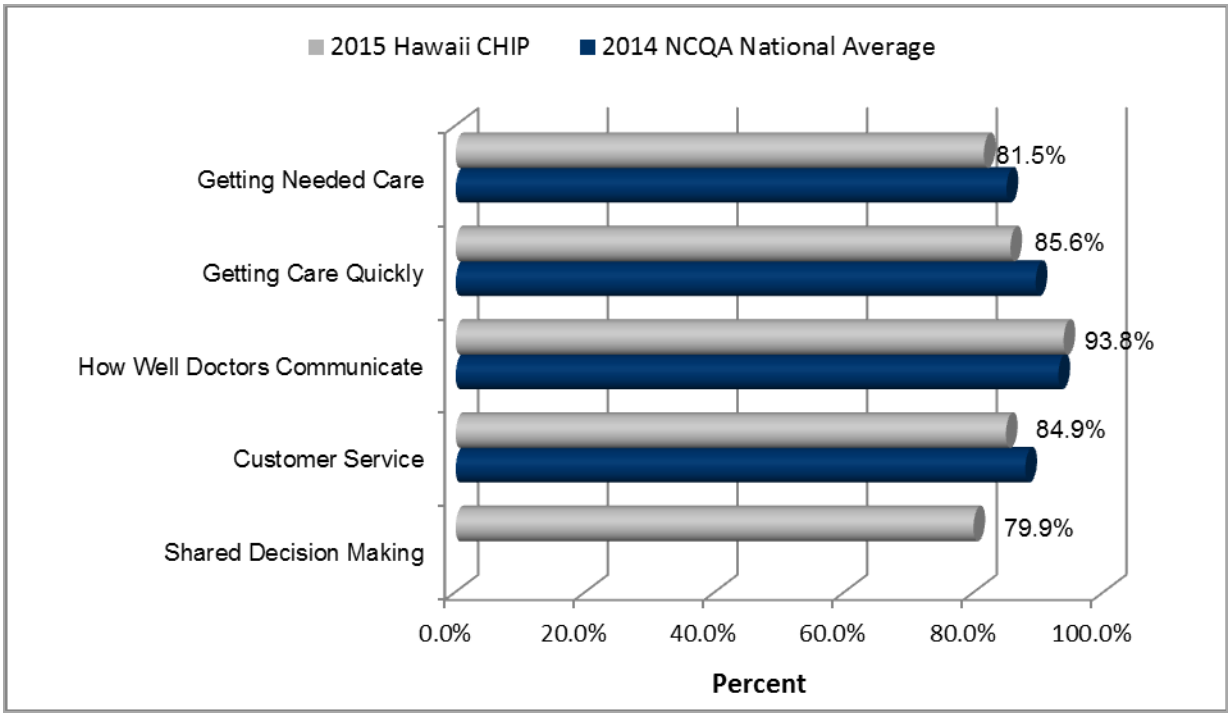
Figure 1-7—CHIP: Global Ratings



+ There were fewer than 100 respondents for the CAHPS measure; therefore, caution should be exercised when interpreting these results.

Figure 1-8 depicts the top-box scores for CHIP and the 2014 NCQA national child Medicaid average for each of the composite measures.

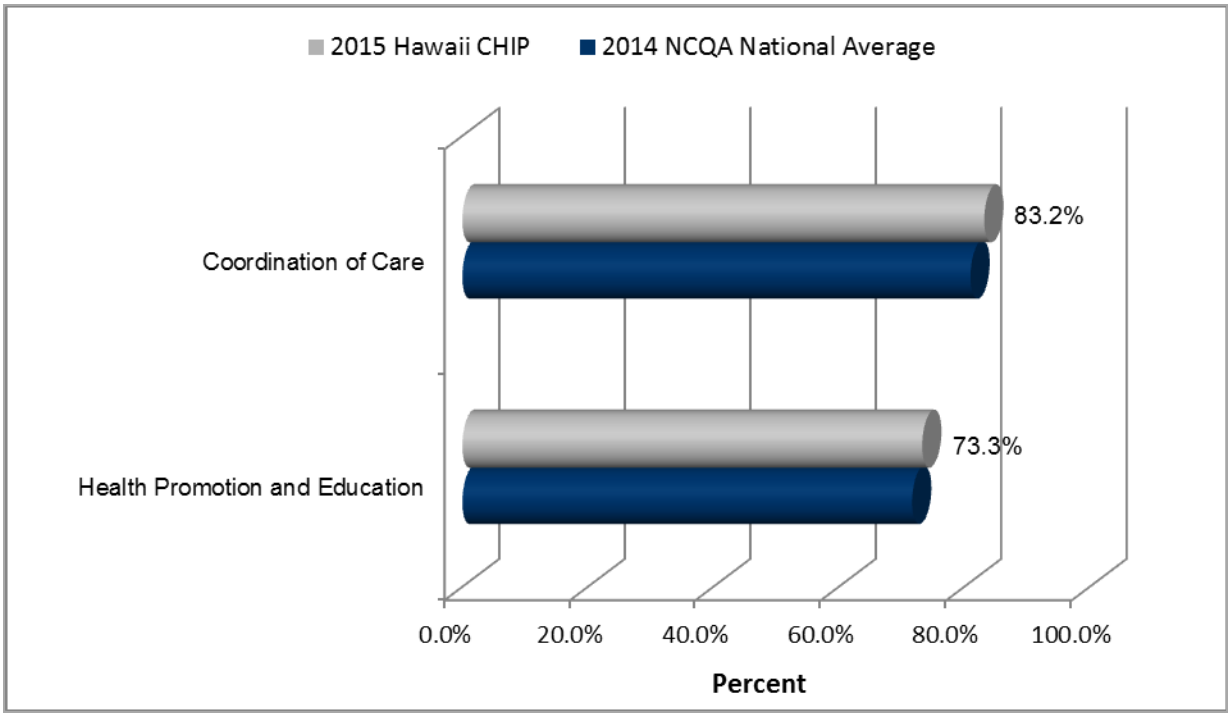
Figure 1-8—CHIP: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.

Figure 1-9 depicts the top-box scores for the statewide CHIP aggregate and the 2014 NCQA national child Medicaid average for each of the individual item measures.

Figure 1-9—CHIP: Individual Item Measures



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

Provider Survey

HSAG conducted a provider survey during 2015 at the request of the MQD. The objective of this activity was to provide meaningful information to the MQD and the health plans about providers' perceptions of the health plans. The survey was last conducted in 2013, and those results were used for comparison purposes to the extent possible.

Description

A sample of Medicaid providers (primary care practitioners and specialists) contracted with or employed by the QI health plans were surveyed to assess satisfaction. Surveys were mailed and follow-up was conducted to increase response rates. Providers had the option of responding to the survey via the mailed hard copy or completing an online version of the survey instrument. Results were compiled and determined within six domains of satisfaction: General Positions, Providing Quality Care, Formulary, Service Coordinators, Specialists, and Behavioral Health.

Because of network model differences, sampling was performed separately for Kaiser providers (N=400) and non-Kaiser providers (N=1,100). Non-Kaiser providers were those contracted with one or more of the QI health plans, excluding Kaiser.

Findings, Conclusions, and Recommendations

- The overall response rate for the 2015 survey of 19.6 percent exceeded the 2013 response rate (5.8 percentage points higher). The response rate of Kaiser providers was higher than non-Kaiser providers (26.4 percent and 17.1 percent, respectively). A total of 260 providers responded to the survey. Approximately one-third of the respondents were PCPs, with the other two-thirds identifying themselves as specialists.
- Comparisons of the health plans' 2015 top-box rates revealed statistically significant differences between plan performance. AlohaCare QI's performance was significantly lower when compared to the aggregate performance of the other plans on two measures. HMSA QI scored significantly higher than the aggregate performance of the other plans on five measures. Kaiser QI's performance was significantly higher than the aggregate performance of the other plans on eight measures. 'Ohana QI scored significantly lower than the aggregate performance of the other plans on seven measures. 'Ohana CCS' performance was significantly lower when compared to the aggregate performance of the other plans on five measures. UHC CP QI performed significantly lower than the aggregate performance of the other plans on eight measures.
- A trending analysis of 2013 top-box rates to their corresponding 2015 top-box scores revealed that none of the health plans showed statistically significant differences in 2015.

Based on the results of this survey, HSAG provided recommendations to the MQD regarding how the health plans might improve provider perceptions and satisfaction. In addition, to continue to increase survey response rates, HSAG provided suggestions to the MQD regarding the survey administration and on how it might increase the number of respondents for future surveys.

State of Hawaii

Department of Human Services

Med-QUEST Division

2016 External Quality Review Report of Results

For the

QUEST Integration Health Plans

and the

Community Care Services Program

March 2017

HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

Overview

The 2016 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) 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 QI health plans and the CCS program. The QI health plans were AlohaCare QUEST Integration Plan (AlohaCare QI), Hawaii Medical Service Association QUEST Integration Plan (HMSA QI), Kaiser Permanente Hawaii QUEST Integration Plan (Kaiser QI), 'Ohana Health Plan QUEST Integration ('Ohana QI), and UnitedHealthcare Community Plan QUEST Integration (UHC CP QI). 'Ohana also has held the contract for the Community Care Services ('Ohana CCS) program since March 2013. CCS is a carved-out behavioral health specialty services plan for individuals who have been determined by the MQD to have a serious mental illness.

According to the federal Medicaid managed care regulations (42 CFR 438), the QI health plans qualify as managed care organizations (MCOs), and the CCS program meets the definition as a pre-paid inpatient health plan (PIHP). Throughout this report, however, the Hawaii MCOs and PIHP will be referred to collectively 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—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). Two optional EQR activities were 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) members using the CAHPS 5.0H Child Medicaid CAHPS survey instruments. While the adult Medicaid survey was conducted at the plan level and provided results at a plan-specific and statewide aggregate level, the CHIP survey was conducted at a statewide level due to small enrollment numbers, producing statewide aggregate results.

This report includes the following for each EQR activity conducted:

- Objectives

[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).

- 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, healthcare services provided by each health plan.

This is the 12th 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 the 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 QI and CCS health plans.

Compliance Monitoring Review of Standards

Description

Calendar year (CY) 2016 began a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program.

For the 2016 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs, using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the (CFR) for five areas of review, or standards. A pre-on-site desk review and an on-site review with interview sessions, system and process demonstrations, and record reviews were conducted.

The second compliance review activity in 2016 involved HSAG's and the MQD's follow-up monitoring of CCS' corrective actions related to its 2015 compliance review, which were all addressed by the end of 2015 or very early 2016. Note: A compliance review was conducted only on the 'Ohana CCS program during 2015. This review brought the CCS program into alignment with the review schedule for the QI plans to ensure all standards are reviewed within a three-year period for all health plans.

Findings, Conclusions, and Recommendations

For the compliance review of health plans and the CCS program, the following tables illustrate the performance of the health plans and the CCS program in each of the standard areas reviewed. For comparison purposes, the statewide average score for the QI health plans is also presented.

Table 1-1—Compliance Standards and Scores

Standard #	Standard Name	AlohaCare QI	HMSA QI	Kaiser QI	'Ohana QI	'Ohana CCS	UHC CP QI	Statewide/ All Plans
I	Member Rights and Protections and Member Information	95%	93%	84%	95%	96%	95%	93%
II	Member Grievance System	98%	94%	97%	98%	98%	98%	97%
III	Access and Availability	100%	95%	95%	95%	100%	100%	98%
IV	Coverage and Authorization	100%	100%	96%	100%	100%	100%	99%
V	Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%
Total Compliance Score:		98%	96%	93%	98%	98%	98%	97%

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.

Statewide areas of strong performance that emerged were Standards V (Coordination and Continuity of Care) at 100 percent, Standard IV (Coverage and Authorization) at 99 percent, Standard III (Access and Availability) at 98 percent, and Standard II (Member Grievance System) at 97 percent. Identified as having the greatest opportunity for improvement was Standard I (Member Rights and Protections and Member Information) at 93 percent.

All but one of the health plans (Kaiser at 93 percent) scored at or above 96 percent for overall total compliance, indicating a high degree of compliance with managed care requirements.

AlohaCare QI's performance across all standards was strong, exceeding the state-wide average for each standard and having three standard areas achieving 100 percent (Access and Availability, Coverage and Authorization, and Coordination and Continuity of Care).

AlohaCare QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until AlohaCare QI is found to be in full compliance with the standards.

HMSA QI's performance across all standards was solid. The health plan met or exceeded the statewide average for three of the five compliance standards, and its 96 percent total compliance score fell just short

of the statewide average of 97 percent. HMSA QI achieved 100 percent scores for two standards (Coverage and Authorization, and Coordination and Continuity of Care).

HMSA QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until HMSA QI is found to be in full compliance with the standards.

Kaiser QI's performance across four of the five standards was also solid. The health plan met or exceeded the statewide average for two of the five compliance standards. However, its 93 percent total compliance score fell short of the statewide average score of 97 percent. Kaiser QI achieved a 100 percent score for one standard (Coordination and Continuity of Care). The Member Rights and Protections and Member Information standard represented the greatest area for improvement, with a score of 84 percent.

Kaiser QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until Kaiser QI is found to be in full compliance with the standards.

'Ohana QI's performance across all standards was strong. Three standards exceeded statewide scores, and one standard was equal to the statewide score at 100 percent (Coordination and Continuity of Care). 'Ohana QI's overall score of 98 percent exceeded the health plans' statewide score from HSAG's review of the same standards (97 percent).

'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until 'Ohana QI is found to be in full compliance with the standards.

'Ohana CCS' performance across all standards was also strong. Four standards exceeded statewide scores, and one standard met the statewide score of 100 percent. 'Ohana CCS had three standard areas achieving 100 percent (Access and Availability, Coverage and Authorization, and Coordination and Continuity of Care). 'Ohana CCS' overall score of 98 percent exceeded the health plans' statewide score from HSAG's review of the same standards (97 percent).

'Ohana CCS was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until CCS is found to be in full compliance with the standards.

UHC CP QI's performance across all standards was strong as well. All standards exceeded statewide scores, and one standard was equal to the statewide score at 100 percent. UHC CP QI had three standard areas achieving 100 percent (Access and Availability, Coverage and Authorization, and Coordination and Continuity of Care). UHC CP QI's overall score of 98 percent exceeded the health plans' statewide score from HSAG's review of the same standards (97 percent).

UHC CP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until UHC CP QI is found to be in full compliance with the standards.

With the completion of these reviews, the health plans and CCS have demonstrated their structural and operational compliance and ability to provide quality, timely, and accessible services. Calendar year 2017 will be the second year in the three-year cycle for compliance reviews. The reviews will target the remaining six standards: Provider Selection, Credentialing, Subcontractual Relationships and Delegation, Practice Guidelines, Quality Assessment and Performance Improvement, and Health Information Systems.

Validation of Performance Measures—NCQA HEDIS Compliance Audits[1-3]

Description

HSAG performed independent audits of the performance measure results calculated by the QUEST Integration (QI) health plans and Community Care Services (CCS) program according to the *2016 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5*. The audit procedures were also consistent with the CMS protocol for performance measure validation: *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[1-4] The health plans that contracted with the Med-QUEST Division (MQD) during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each NCQA HEDIS Compliance Audit 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. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health.

The measurement period was CY 2015 (January 1, 2015, through December 31, 2015), and the audit activities were conducted concurrently with HEDIS 2016 reporting. The five QI health plans (AlohaCare QI, HMSA QI, Kaiser QI, 'Ohana QI, and UHC CP QI) were required to report the QI, aged, blind, or disabled (ABD), and non-ABD measures. In addition, 'Ohana CCS was required to report rates for the CCS program-specific measures.

During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 31 measures, yielding a total of 96 measure indicators, for the QI population. For the ABD population, health plans were required to report on 32 measures, yielding a total of 100 measure indicators. The health plans were required to report on 30 measures, yielding a total of 95 measure indicators, for the non-ABD population. 'Ohana CCS was required to report on 10 measures, yielding a total of 16 measure indicators, for the CCS program. The measures were organized into categories, or domains, to evaluate

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

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Sept 27, 2016.

the health plans' performance and the quality and timeliness of, and access to, Medicaid care and services. These domains included:

- Access to Care
- Effectiveness of Care
- Children's Preventive Care
- Women's Health
- Care for Chronic Conditions
- Behavioral Health
- Utilization and Health Plan Descriptive Information

Findings, Conclusions and Recommendations

HSAG evaluated each health plan's compliance with NCQA's IS standards. All health plans were fully compliant with all standards and able to report valid performance measure rates. All health plans used software vendors that participated in NCQA's measure certification program to generate the rates required by MQD. However, Kaiser QI calculated two measures using internally developed programming code. All health plans used supplemental data to augment their internal claims/encounter data, which is allowable for HEDIS reporting.

HSAG analyzed the health plan-specific performance measure results for the combined QI population, as well as rates for the non-ABD and ABD populations, and the CCS program. For each performance measure indicator within this report, HSAG compared the HEDIS 2016 results to the NCQA national Medicaid HEDIS 2015 Audit Means and Percentiles and, where appropriate, performed significance testing to determine statistically significant changes between 2015 and 2016. Additionally, HSAG compared 18 measure indicators to Quality Strategy targets established by the MQD based on the national 2015 HEDIS Medicaid HMO percentiles.[1-5] The MQD Quality Strategy targets are defined in Section 3 (Plan-Specific Results, Conclusions, and Recommendations) in Table 3-7.

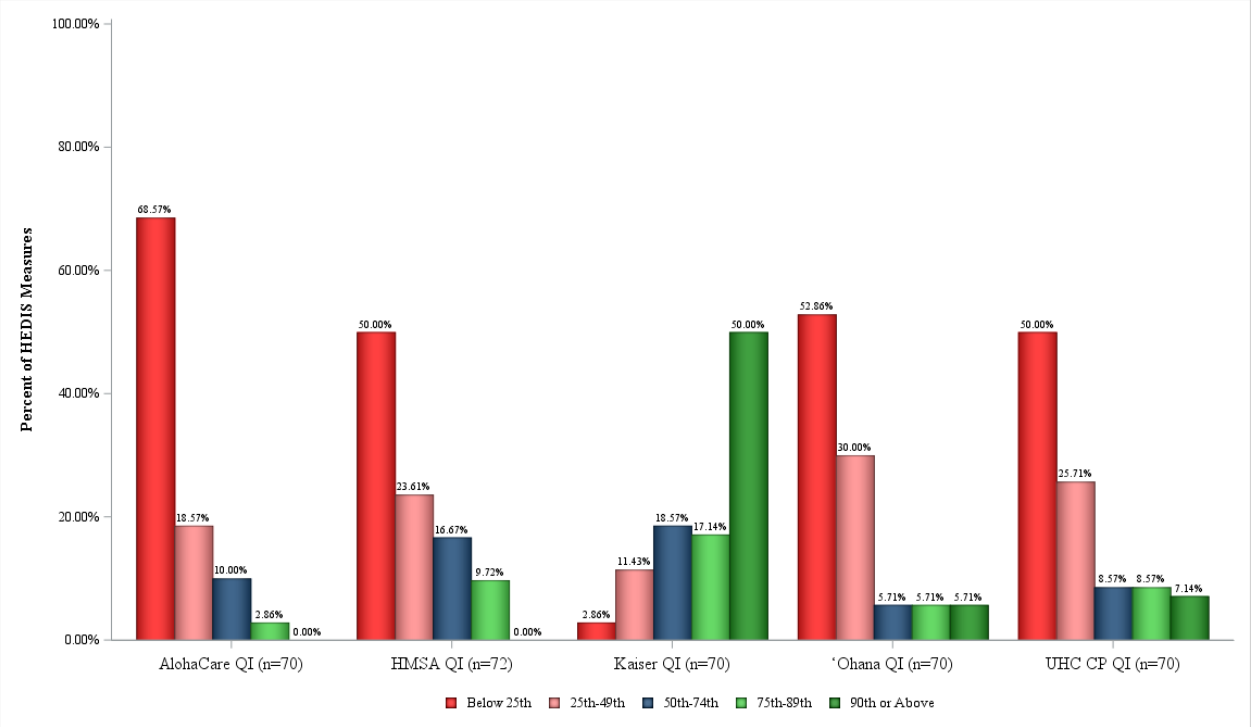
QI Performance Measure Results

The health plans reported and HSAG validated 96 HEDIS 2016 performance measure indicators for the QI population, of which up to 72 indicators were compared to national Medicaid percentiles.[1-6] Of note, 2016 is the first year that rates for the QI population were evaluated by HSAG. Figure 1-1 displays the health plans' performance compared to the national Medicaid percentiles.

[1-5] Since national Medicaid benchmarks are not available for the *Medication Reconciliation Post-Discharge* measure, this measure was compared to national Medicare benchmarks. Caution should be exercised when comparing Medicaid rates to the corresponding Medicare percentiles.

[1-6] The *Inpatient Utilization-General Hospital/Acute Care* and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, national Medicaid percentiles do not exist for *Plan All-Cause Readmissions* and *Colorectal Cancer Screening*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

Figure 1-1—Comparison of QI Measure Indicators to HEDIS Medicaid National Percentiles



Please note: Percentages may not total 100% due to rounding.

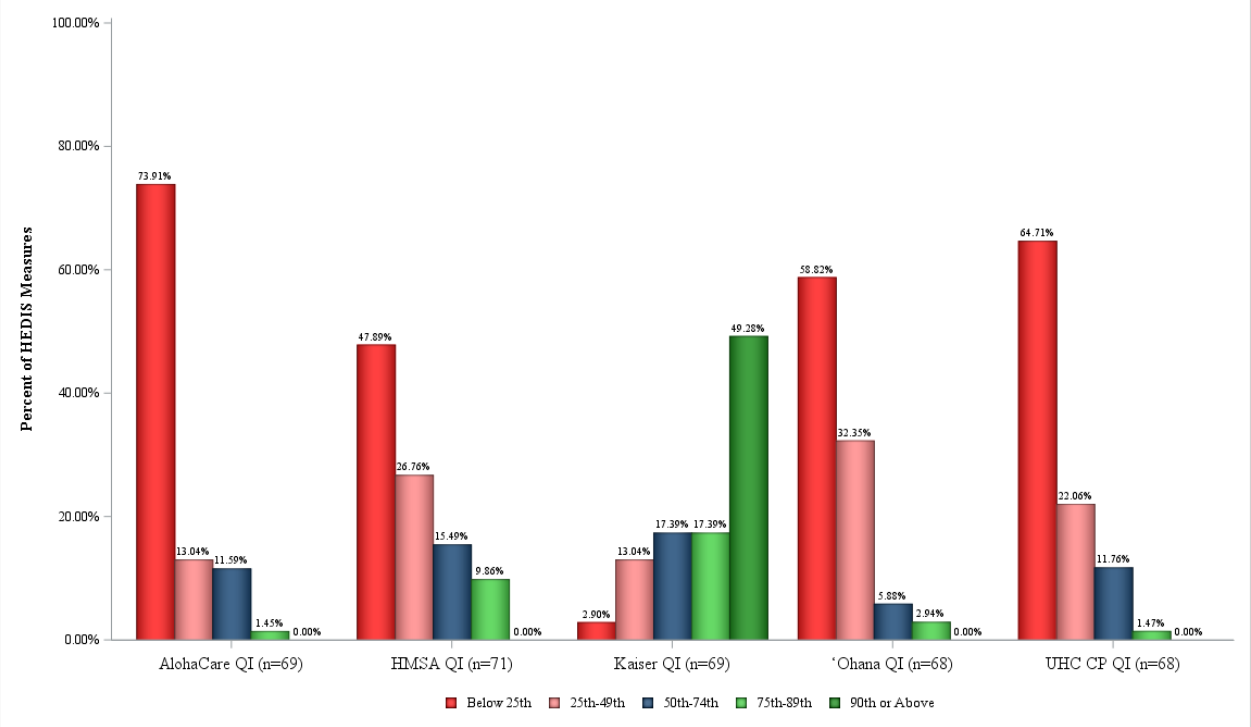
As presented in Figure 1-1, health plan performance was diverse for the QI population. The highest-performing health plan was Kaiser QI, with approximately 67 percent of its measure indicator rates ranking at or above the national Medicaid 75th percentile and 50 percent of these measures ranking at or above the national Medicaid 90th percentile. Conversely, the majority of the remaining health plans' QI population rates fell below the national Medicaid 25th percentile, with 50 percent of HMSA QI's and UHC CP QI's rates falling below the national Medicaid 25th percentile, roughly 53 percent of 'Ohana QI's rates falling below the national Medicaid 25th percentile, and approximately 69 percent of AlohaCare QI's rates falling below the national Medicaid 25th percentile.

In addition, all five health plans had reportable rates for the 18 measures with MQD Quality Strategy targets that were specific to the QI population. Thirteen of Kaiser QI's rates (72 percent) met or exceeded the MQD Quality Strategy targets. Five of UHC CP QI's rates (28 percent) met or exceeded the MQD Quality Strategy targets. Two of 'Ohana QI's rates (11 percent) met or exceeded the MQD Quality Strategy targets, and one of HMSA's QI rates (6 percent) met or exceeded the MQD Quality Strategy targets. None of AlohaCare QI's rates met the MQD Quality Strategy targets.

Non-ABD Performance Measure Results

The health plans reported and HSAG validated 95 performance measure indicators for the non-ABD population, of which up to 71 indicators were compared to national Medicaid percentiles.[1-7] Figure 1-2 displays the health plans' performance compared to the national Medicaid percentiles.

Figure 1-2—Comparison of Non-ABD Measure Indicators to HEDIS Medicaid National Percentiles



Please note: Percentages may not total 100 percent due to rounding.

Health plan performance varied for the non-ABD population, with Kaiser QI's performance exceeding that of the other QI health plans when compared to national Medicaid percentiles. Approximately 67 percent of Kaiser QI's rates ranked at or above the national Medicaid 75th percentile, with roughly 49 percent of these measure rates ranking at or above the national Medicaid 90th percentile. Conversely, most of the remaining health plans' QI population rates fell below the national Medicaid 25th percentile. Specifically, approximately 74 percent of AlohaCare QI's rates, 48 percent of HMSA QI's rates, 59 percent of 'Ohana QI's rates, and 65 percent of UHC CP QI's rates fell below the national Medicaid 25th percentile.

While the QI has 18 measures, the non-ABD had 17 measures. For the measures that were specific to the non-ABD population, all five health plans had reportable rates for the 17 measures with MQD Quality Strategy targets. Thirteen measure indicator rates reported by Kaiser QI (76 percent) met or exceeded

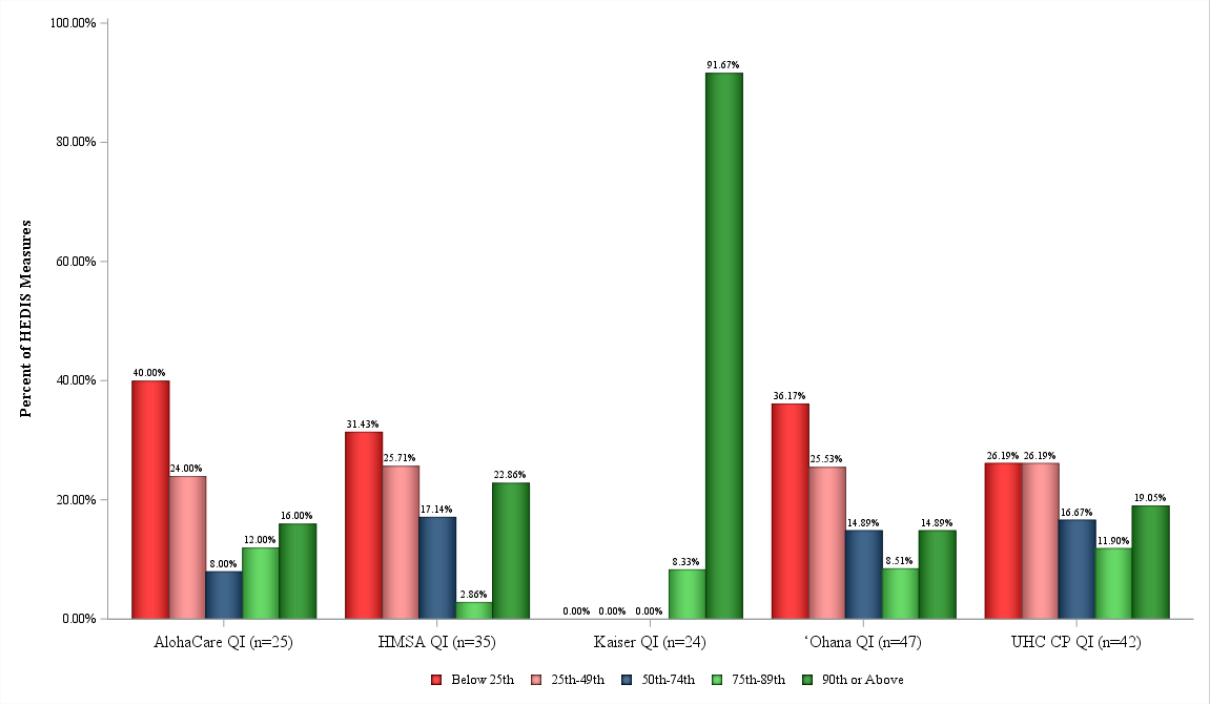
[1-7] The *Enrollment by Product Line, Inpatient Utilization-General Hospital/Acute Care,* and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, national Medicaid percentiles do not exist for *Plan All-Cause Readmissions* and *Colorectal Cancer Screening*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

the MQD Quality Strategy targets, and one of HMSA QI's reported rates (6 percent) met or exceeded the MQD Quality Strategy target. None of AlohaCare QI's, 'Ohana QI's, or UHC CP QI's rates met the MQD Quality Strategy targets.

ABD Performance Measure Results

The health plans reported and HSAG validated 100 ABD population performance measure indicators, of which up to 47 indicators were compared to national Medicaid percentiles.[1-8] Of note, HSAG evaluated ABD population rates for 'Ohana QI and UHC CP QI in 2015, but 2016 is the first year that HSAG evaluated ABD rates for the remaining health plans. Figure 1-3 displays the health plans' performance compared to the national Medicaid percentiles.

Figure 1-3—Comparison of ABD Measure Indicators to HEDIS Medicaid National Percentiles



Please note: Percentages may not total 100 percent due to rounding.

As presented in Figure 1-3, the highest-performing health plan was Kaiser QI, with all of its measure rates ranking at or above the national Medicaid 75th percentile and approximately 92 percent these measure rates ranking at or above the national Medicaid 90th percentile. Rates for the remaining health plans demonstrated mixed performance compared to the national Medicaid percentiles. Roughly one-third of UHC CP QI's rates ranked at or above the national Medicaid 75th percentile, but more than 50 percent fell below the national Medicaid 50th percentile, with approximately 26 percent of the rates

[1-8] The *Enrollment by Product Line*, *Inpatient Utilization—General Hospital/Acute Care* and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, national Medicaid percentiles do not exist for *Plan All-Cause Readmissions*, *Care for Older Adults*, *Colorectal Cancer Screening*, and *Medication Reconciliation Post-Discharge*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

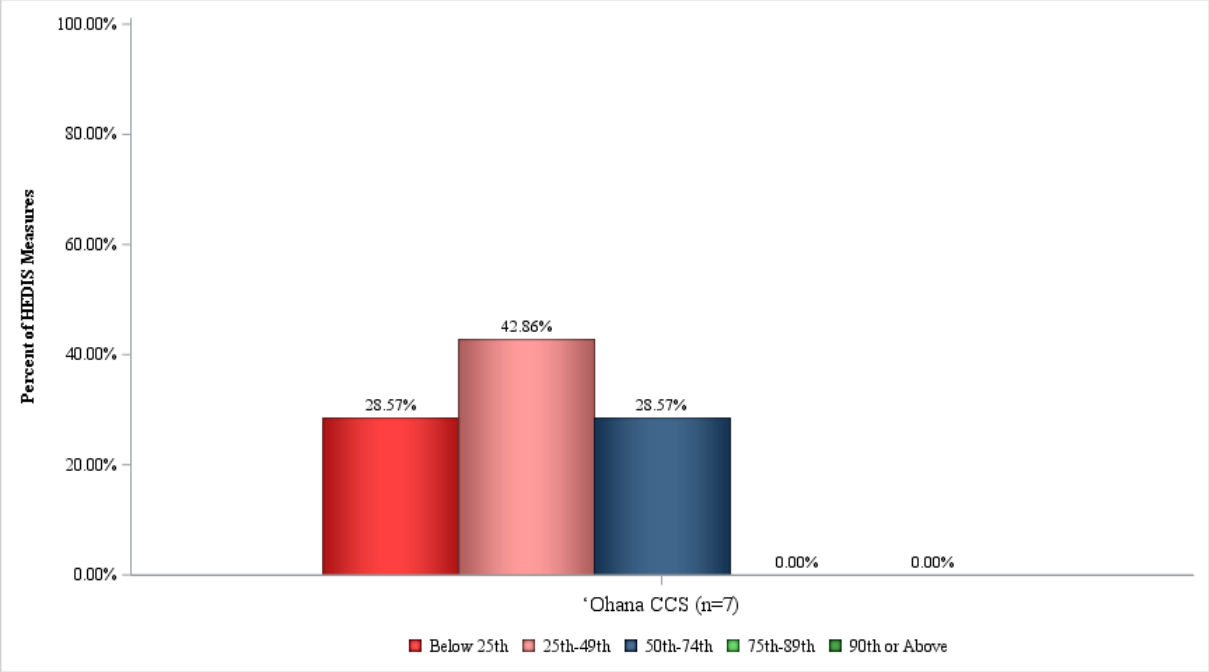
falling below the national Medicaid 25th percentile. Further, approximately one-quarter of AlohaCare QI's, HMSA QI's, and 'Ohana QI's rates ranked at or above the national Medicaid 75th percentile, but the majority of these health plans' rates fell below the national Medicaid 50th percentile.

While the QI has 18 measures, the ABD had 17 measures. Of the 17 ABD population measures with MQD Quality Strategy targets, Kaiser QI had reportable rates for 10 of these measure indicators, and nine of these rates (90 percent) met or exceeded the MQD Quality Strategy targets. Of the 17 measure indicators that were reportable for 'Ohana QI, four rates (24 percent) met or exceeded the MQD Quality Strategy targets. Of the 14 measure indicators that were reportable for UHC CP QI, three rates (21 percent) met or exceeded the MQD Quality Strategy targets. Of the 12 reportable rates for HMSA QI, one rate (8 percent) met or exceeded the MQD Quality Strategy targets. None of AlohaCare QI's rates met the MQD Quality Strategy targets.

CCS Performance Measure Results

'Ohana CCS reported and HSAG validated 16 indicator rates, of which seven indicators were compared to national Medicaid percentiles.[1-9] HSAG evaluated the CCS program rates for 'Ohana CCS in 2015 and 2016. Figure 1-4 displays 'Ohana CCS program performance compared to the national Medicaid percentiles.

Figure 1-4—Comparison of 'Ohana CCS' Rates to HEDIS Medicaid National Percentiles



Please note: Percentages may not total 100 percent due to rounding.

[1-9] The *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, national Medicaid percentiles do not exist for *Plan All-Cause Readmissions* or the two non-HEDIS measures: *Behavioral Health Assessment* and *Follow-up with Assigned PCP Following Hospitalization for Mental Illness.* For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

As presented in Figure 1-4, none of 'Ohana CCS' reported rates ranked at or above the national Medicaid 75th percentile. Conversely, approximately 71 percent of 'Ohana CCS' rates fell below the national Medicaid 50th percentile, with approximately 29 percent of these rates falling below the national Medicaid 25th percentile. 'Ohana CCS' did not meet the MQD Quality Strategy targets for *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* and *Follow-Up Within 30 Days of Discharge*. These were the only measures with MQD Quality Strategy targets for the CCS program.

Recommendations for improvement are presented in the population and health plan-specific results sections of this report. In general, HSAG recommends that each health plan focus on improving performance related to the measure indicators with rates that fell below the national Medicaid 25th percentile to determine if interventions are warranted, focusing efforts on identifying improvement strategies that could be leveraged to improve all rates for each population.

Validation of Performance Improvement Projects (PIPs)

Description

PIPs are designed as an organized way to assist health plans in assessing their healthcare processes, implementing process improvements, and improving outcomes of care. In 2016, HSAG validated two PIPs for each of the QI and CCS health plans, for a total of 12 PIPs. The five QUEST Integration plans were required by the MQD to conduct PIPs related to *All-Cause Readmissions* and a second topic to improve *Diabetes Care*. The *All-Cause Readmissions* PIP topic is a key focus of the MQD's quality strategy. CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment.*

The goal of HSAG's PIP validation is to ensure that the health plan and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP. In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes in order to determine the most effective strategies for achieving real improvement. To illustrate how the rapid-cycle PIP framework continued to meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-10] HSAG presented the crosswalk and new PIP framework components to CMS, and

[1-10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2016.

CMS agreed that with the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern PIPs within healthcare settings, a new approach was reasonable, approving HSAG's rapid-cycle PIP framework for validation of PIPs for the State of Hawaii.

Validation Overview

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the health plan with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings. HSAG's validation of rapid-cycle PIPs includes the following two key components of the quality improvement process:

- Evaluation of the technical structure to determine whether a PIP's initiation (i.e., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation through the use of PDSA cycles, and sustainability and spreading successful change. This component evaluates how well the health plan executed its quality improvement activities and whether the desired aim was achieved and sustained.

Findings, Conclusions, and Recommendations

All of the health plans progressed to testing interventions for the rapid-cycle PIPs in the 2016 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plans received recommendations from HSAG for the initial review of the Module 4 submissions. All of the health plans satisfactorily addressed HSAG's recommendations and feedback in the resubmitted Module 4s. The health plans had not yet progressed to reporting healthcare measure outcomes at the time of the validation. Following the review and validation of the health plans' 2016 PIPs, HSAG concluded that overall:

- The performance on the PIPs suggests that the health plans were able to successfully complete the first Module 4 submission (intervention testing using PDSA) for each PIP topic after receiving feedback from HSAG.
- The health plans should be cognizant of timing of interventions. If there are delays with beginning intervention testing, there may not be enough data points to determine meaningful and sustained improvement by the specific, measurable, attainable, relevant, and time-bound (SMART) Aim end date.
- The PIP process should be a learning experience that provides participating team members and organizations with new knowledge and skills that can be applied in ongoing quality improvement efforts.

- Module 5 (PIP conclusions) will be submitted within a few weeks of the SMART Aim end date (December 31, 2016). The conclusion of the PIP should be used as a springboard for sustaining improvement achieved and attaining new improvement.
- In Module 5, the health plans should provide an accurate summary of the overall key findings and interpretation of results.
- In Module 5, the health plans should document lessons learned and a plan for spreading successful interventions beyond the initial scope of the project.
- The health plans should request technical assistance from HSAG at any point in the process, if needed.

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

Description

The CAHPS health plan surveys are standardized survey instruments which measure members' satisfaction levels with their healthcare. For 2016, HSAG administered the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members of the QI health plans, as well as a CHIP-eligible CAHPS 5.0 survey of members via a statewide sampling methodology, who met age and enrollment criteria. All members of sampled adult Medicaid and CHIP members completed the surveys from February to May 2016 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.[1-11] 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 and Conclusions for the QI Health Plans

For the QI health plans and the statewide QI Program aggregate, 2016 scores were compared to the 2015 NCQA national adult Medicaid average, and the following results were noted:

- The QI Program aggregate scores exceeded the NCQA national adult Medicaid average on nine of the 11 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*,

[1-11] Please note that administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.0H Adult Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required in order to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.

Rating of Specialist Seen Most Often, *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.

- AlohaCare QI scored above the NCQA national adult Medicaid average on seven of the 11 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- HMSA QI scored above the NCQA national adult Medicaid average on seven of the 11 measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- Kaiser QI scored above the NCQA national adult Medicaid average on 10 of the 11 measures: *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*, *Customer Service*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- 'Ohana QI scored above the NCQA national adult Medicaid average on nine of the 11 measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- UHC CP QI scored above the NCQA national adult Medicaid average on eight of the 11 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Customer Service*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.

Figure 1-5 depicts the 2016 top-box scores for the statewide QI Program aggregate and the 2015 NCQA national adult Medicaid average for each of the global ratings.

Figure 1-5—QI Program Aggregate: Global Ratings

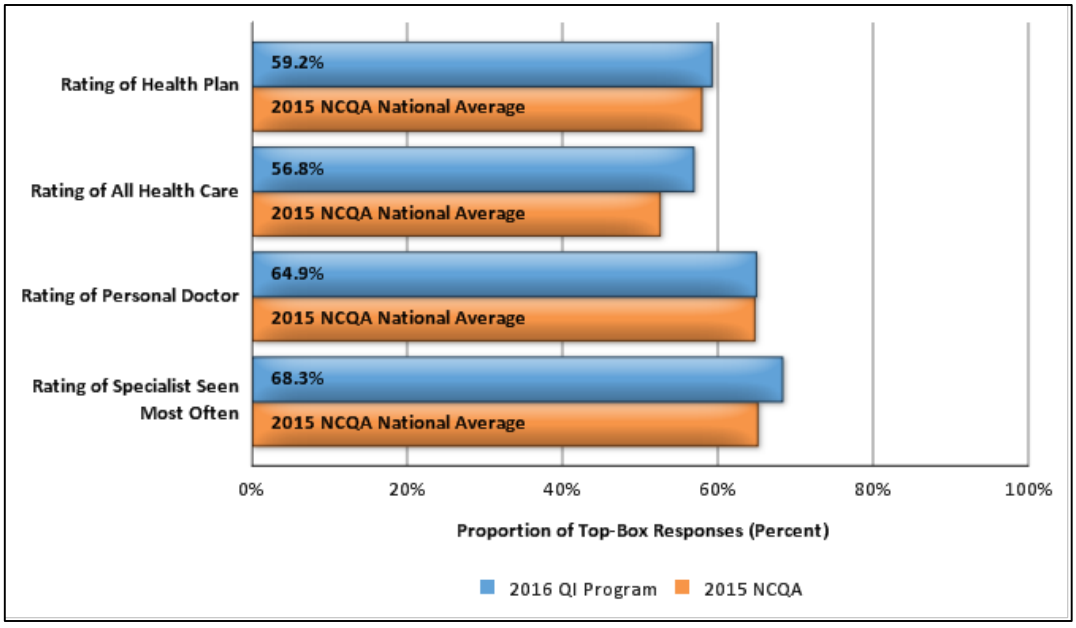


Figure 1-6 depicts the 2016 top-box scores for the statewide QI Program aggregate and the 2015 NCQA national adult Medicaid average for each of the composite measures.

Figure 1-6—QI Program Aggregate: Composite Measures

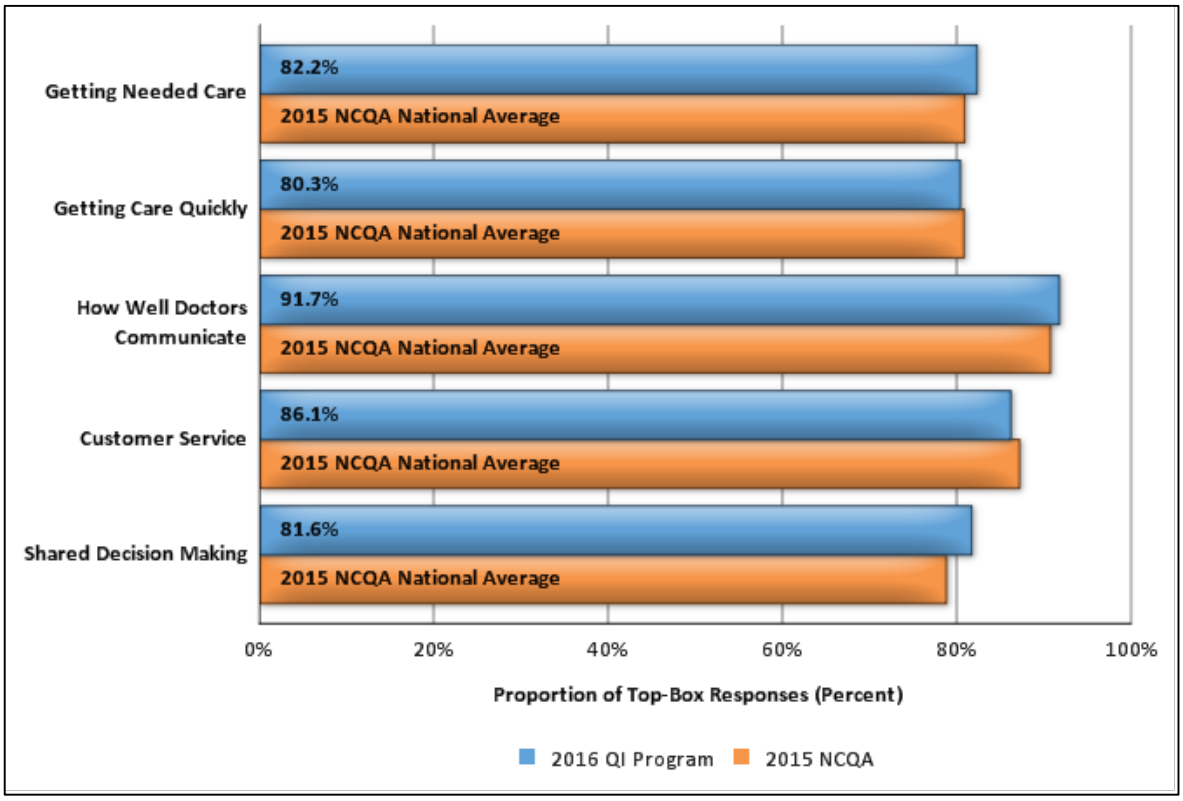
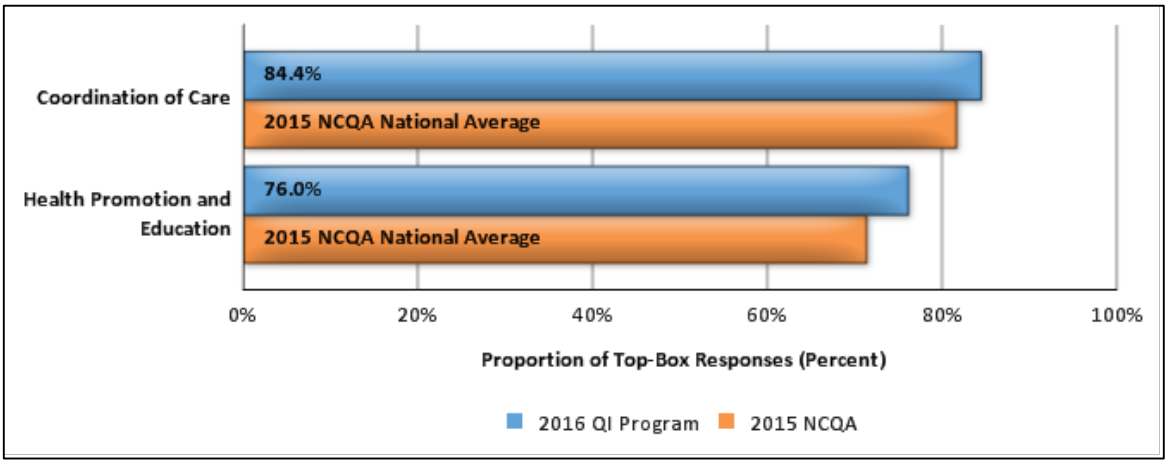


Figure 1-7 depicts the 2016 top-box scores for the statewide QI Program aggregate and the 2015 NCQA national adult Medicaid average for each of the individual item measures.

Figure 1-7—QI Program Aggregate: Individual Item Measures



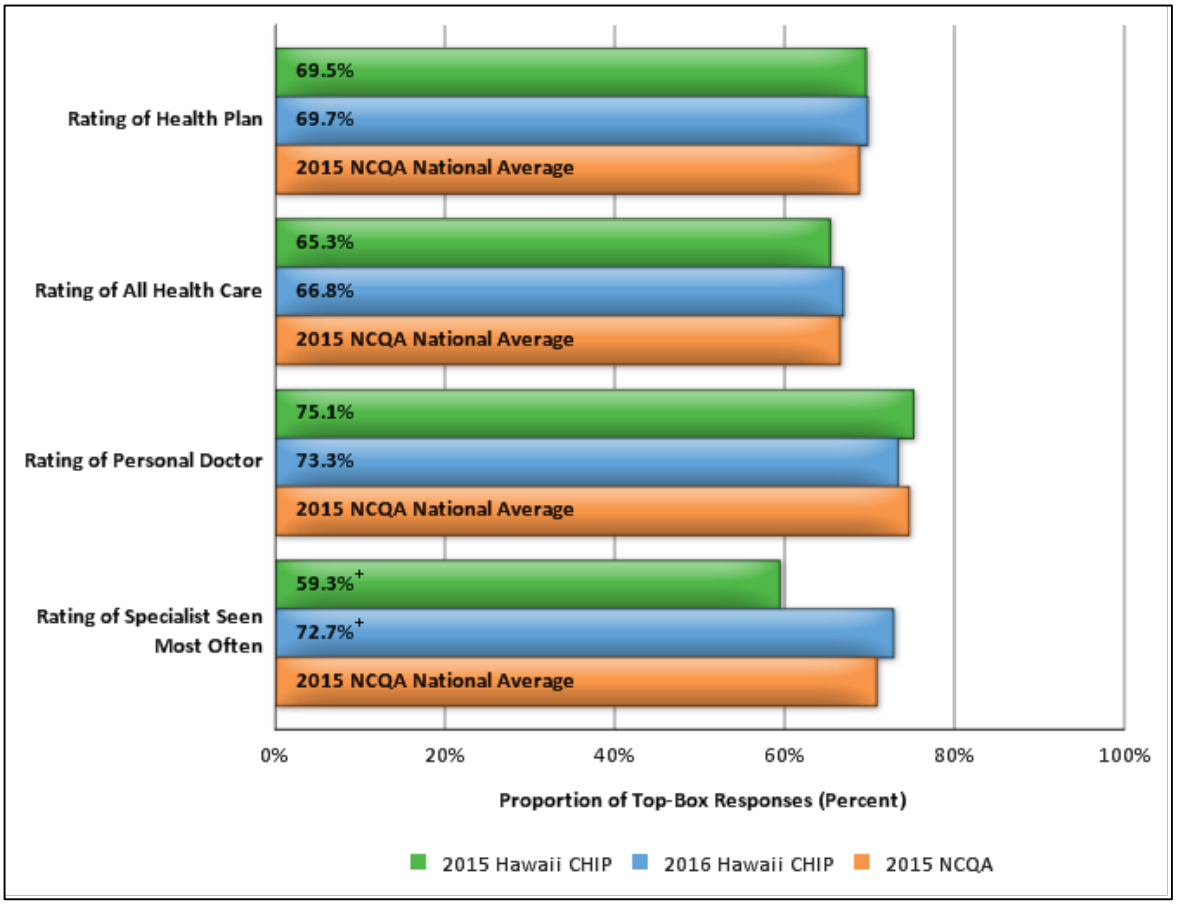
Findings and Conclusions for CHIP

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 2015 NCQA national child Medicaid average, the following results were noted for the CHIP population:

The 2016 CHIP Program scores were above the 2015 NCQA national child Medicaid average on six of the 11 reportable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Health Promotion and Education*.

Figure 1-8 depicts the 2015 and 2016 top-box scores for CHIP and the 2015 NCQA national child Medicaid average for each of the global ratings.

Figure 1-8—CHIP: Global Ratings



+ There were fewer than 100 respondents for the CAHPS measure; therefore, caution should be exercised when interpreting these results.

Figure 1-9 depicts the 2015 and 2016 top-box scores for CHIP and the 2015 NCQA national child Medicaid average for each of the composite measures.

Figure 1-9—CHIP: Composite Measures

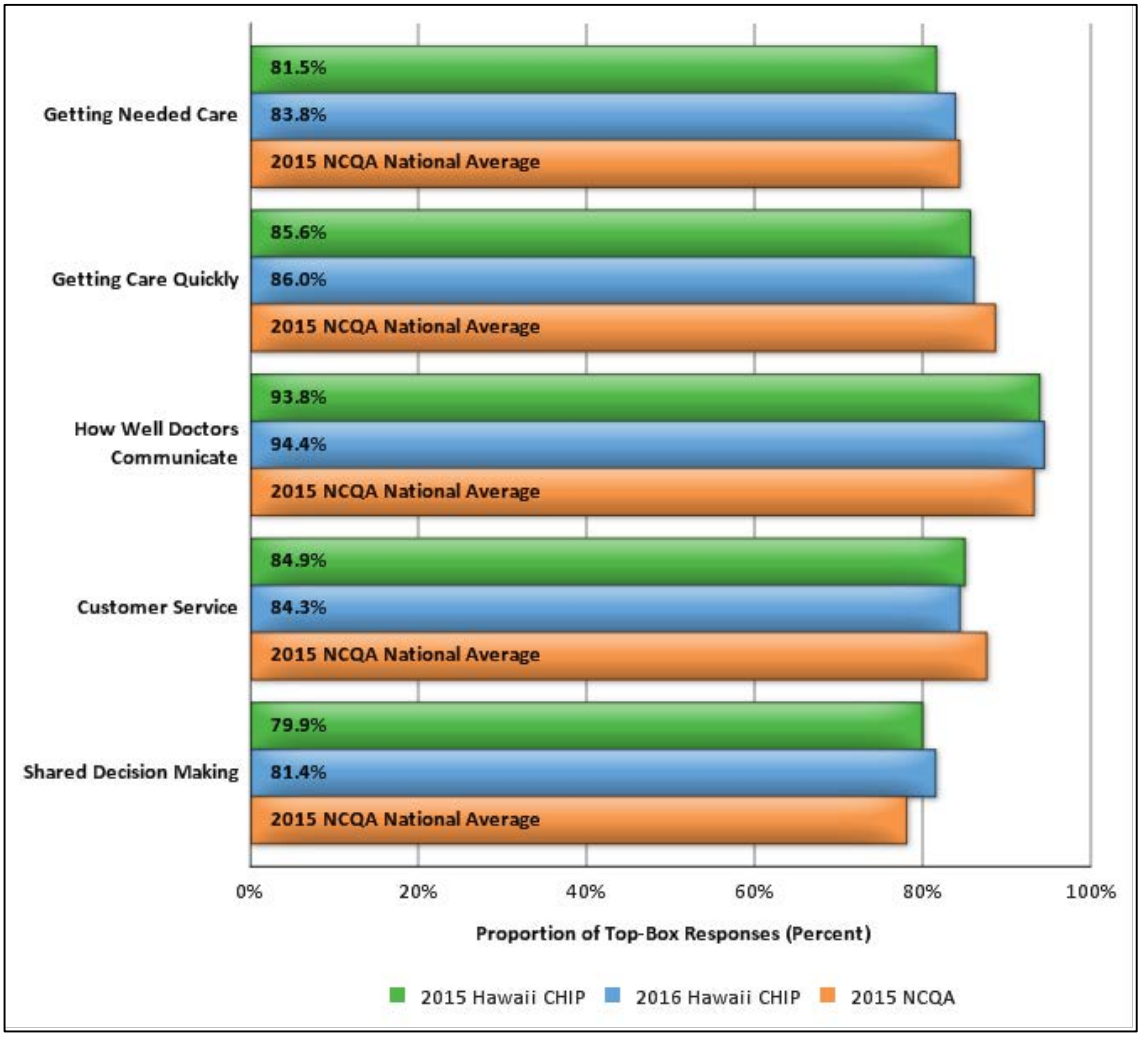
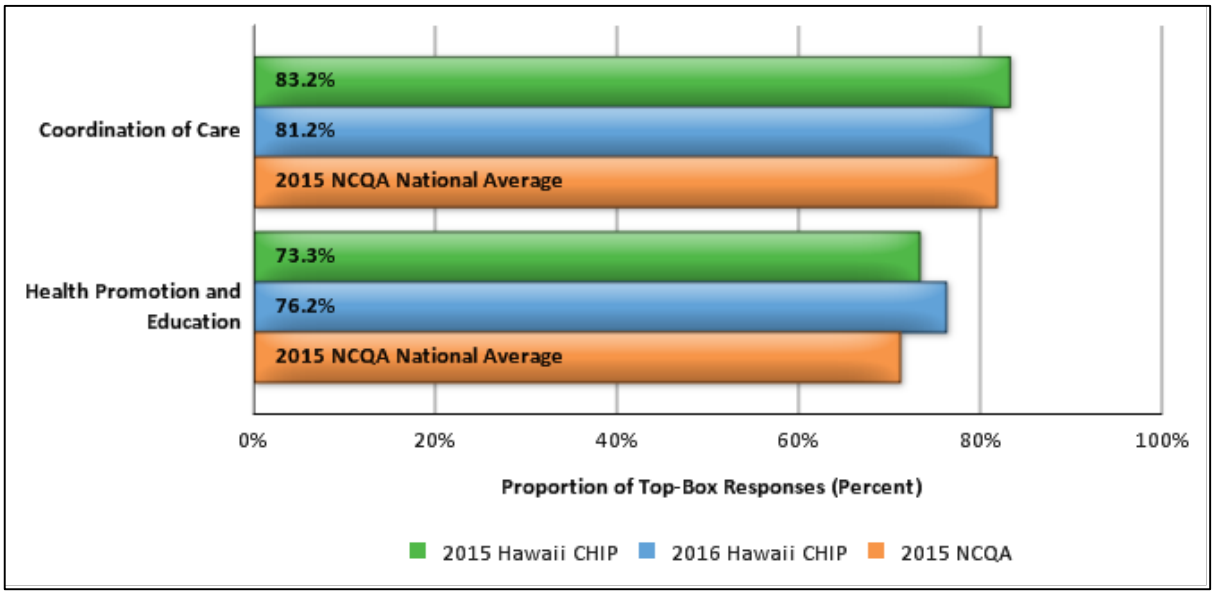


Figure 1-10 depicts the 2015 and 2016 top-box scores for the statewide CHIP aggregate and the 2015 NCQA national child Medicaid average for each of the individual item measures.

Figure 1-10—CHIP: Individual Item Measures



Provider Survey

HSAG conducted a provider survey during 2016 at the request of the MQD. The objective of this activity was to provide meaningful information to the MQD and the QI health plans about providers' perceptions of the QI health plans. The results of the 2016 Hawaii Provider Survey questions were presented by five domains of satisfaction related to general positions, providing quality care, non-formulary, service coordinators, and specialists.

Findings and Conclusions

Standard tests of statistical significance were conducted to determine if statistically significant differences in QI health plan performance existed between the QI health plans' 2016 top-box rates. As is standard in most survey implementations, a "top-box" rate is defined by a positive or satisfied response. Below is a summary of the statistically significant differences that existed between the 2016 "top-box" rates of the QI health plans.

- AlohaCare QI's 2016 top-box rate for adequacy of specialists (6.6 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- HMSA QI's 2016 top-box rates for compensation satisfaction and timeliness of claims payments (35.7 percent and 58.0 percent, respectively) were both higher than the aggregate rates of the other QI health plans, and the differences were statistically significant.

- HMSA QI's 2016 top-box rate for prior authorization process (16.8 percent) was higher than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- HMSA QI's 2016 top-box rate for adequacy of specialists (21.6 percent) was higher than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- Kaiser QI's 2016 top-box rates for compensation satisfaction and timeliness of claims payments (63.4 percent and 61.5 percent, respectively) were both higher than the aggregate rates of the other QI health plans, and the differences were statistically significant. Also, no providers were dissatisfied with the timeliness of claims payments from Kaiser QI.
- Kaiser QI's 2016 top-box rates for prior authorization process and formulary (32.4 percent and 56.3 percent, respectively) were both higher than the aggregate rates of the other QI health plans, and the differences were statistically significant. Also, no providers indicated that Kaiser QI's formulary negatively impacted their ability to provide quality care.
- Kaiser QI's 2016 top-box rate for adequate access to non-formulary drugs (72.9 percent) was higher than the aggregate rate of the other QI health plans, and the difference was statistically significant. Also, no providers were dissatisfied with the adequacy of Kaiser QI's access to non-formulary drugs.
- Kaiser QI's 2016 top-box rate for helpfulness of service coordinators (75.0 percent) was higher than the aggregate of the other QI health plans, and the difference was statistically significant. Also, no providers were dissatisfied with the adequacy of the help provided by Kaiser QI's service coordinators.
- Kaiser QI's 2016 top-box rates for adequacy of specialists and adequacy of behavioral health specialists (80.0 percent and 23.9 percent, respectively) were both higher than the aggregate rates of the other QI health plans, and the differences were statistically significant.
- 'Ohana QI's 2016 top-box rates for compensation satisfaction and timeliness of claims payments (12.6 percent and 24.0 percent, respectively) were both lower than the aggregate rates of the other QI health plans, and the differences were statistically significant.
- 'Ohana QI's 2016 top-box rate for formulary (6.1 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- 'Ohana QI's 2016 top-box rate for adequate access to non-formulary drugs (1.3 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- 'Ohana QI's 2016 top-box rate for helpfulness of service coordinators (9.2 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- 'Ohana QI's 2016 top-box rate for adequacy of specialists (5.0 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- UHC CP QI's 2016 top-box rates for compensation satisfaction and timeliness of claims payments (15.6 percent and 29.8 percent, respectively) were both lower than the aggregate rates of the other QI health plans, and the differences were statistically significant.
- UHC CP QI's 2016 top-box rate for formulary (8.4 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- UHC CP QI's 2016 top-box rate for adequate access to non-formulary drugs (1.3 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.

- UHC CP QI's 2016 top-box rate for helpfulness of service coordinators (10.3 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- UHC CP QI's 2016 top-box rates for adequacy of specialists and adequacy of behavioral health specialists (both 3.7 percent) were both lower than the aggregate rates of the other QI health plans, and the differences were statistically significant.

Recommendations

The Provider Survey revealed opportunities to improve provider satisfaction. Kaiser QI's rate was higher than the aggregate rate of the other plans on all domains, and the difference was statistically significant. Conversely, 'Ohana (WellCare) QI and UHC CP QI exhibited the most opportunity for improvement, with rates lower than the aggregate rate of the other plans on nearly all domains.

Based on these results, the following are general quality improvement recommendations that the plans and the MQD should consider to increase or maintain a high level of provider satisfaction.[1-12] The MQD and each plan should evaluate these general recommendations in the context of their own operational and quality improvement activities.

- HSAG recommends that the MQD evaluate 'Ohana (WellCare) QI's and UHC CP QI's performance on the various domains evaluated as part of the survey, based on the provider's feedback. The issues/concerns expressed by providers with these two plans may cause some providers to leave the Medicaid market, which would add to the provider shortage and provider access issue in the State of Hawaii.
- Providers consistently expressed concerns in getting adequate specialty care due to the immense lack of specialists. The process to refer patients to specialists was noted as especially difficult. The shortage of specialists on the island requires patients to travel to get care, but limitations related to availability and travel arrangements prevent many patients from being seen in a timely manner. Providers are becoming overwhelmed by the growing demand, while many members are being left with nowhere to go. HSAG recommends the MQD and the QI health plans collaborate on a solution to this issue, such as provider recruitment and retention, and focus on the patient-centered medical home (PCMH) model of care.
- Some providers indicated that the prior authorization process has a negative impact on their ability to provide quality care. QI health plans could work toward programming medical services and drugs that require prior authorization into their systems and workflows to automate the process (e.g., expand availability and interoperability of health information technology). The MQD can work with the QI health plans to support the simplification and standardization of the preauthorization forms and process.
- Providers' feedback indicated that opportunities still exist to ensure that QI health plans have adequate access to non-formulary drugs. QI health plans typically choose which drugs to include in

[1-12] Brodsky, Karen L. "Best Practices in Specialty Provider Recruitment and Retention: Challenges and Solutions." *HealthWorks Consulting, LLC*, 2005.

the formulary. The MQD should consider working with the QI health plans to establish standard policies and procedures to ensure adequate access to non-formulary drugs.

- Periodic provider focus groups could be implemented to gain further valuable information and insight into areas of poor performance as described in the survey feedback. Hearing about specific scenarios and examples of provider issues may help the QI health plans in understanding and targeting areas needing performance improvement. QI health plans could then use a performance improvement project approach to determine interventions and perform a targeted remeasurement of provider satisfaction at a later date.

Future Survey Administration Recommendations for the MQD

HSAG recommends continued administration of the provider survey every two years. This remeasurement would provide valuable trending information to the MQD, providers, the general public, as well as the QI health plans. Trending the data will allow QI health plans to determine which areas they have improved and which areas require direct improvement efforts. HSAG recommends that the MQD use the same survey instrument to allow for trending. HSAG also recommends that the MQD continue to oversample in order to increase the number of providers that participate in the survey.

HSAG recommends that the MQD continue to employ alternative approaches to increase provider participation in the survey. Increasing the overall number of respondents to the survey reduces the likelihood of nonresponse bias and increases the likelihood that the responses reflect those of all providers serving QI members. Some specific recommended strategies follow:

- Informing QI health plans and/or providers of a future survey can greatly increase the number of responses. A survey notification, in the form of a letter or an email, could be sent from the MQD prior to administering the survey to inform QI health plans and/or providers about the upcoming survey, estimated timeline for administration, and when and how the survey results will be made available. Additionally, to augment the cover letter included with the mailed survey, the MQD could stress the importance of provider participation in the reminder notice and encourage providers to complete the survey when it arrives. The MQD should continue its work with QI health plans and request that they send reminder notifications to providers or publish an announcement in provider newsletters, encouraging them to participate in the survey.
- HSAG recommends that the MQD collect email addresses for its QI providers to ensure this information is captured in the MQD's provider database system from which the provider survey sample is taken. Alternatively, the MQD could work with the QI health plans to obtain this email contact information.
- A web-based survey is an easy and convenient way for providers to respond to the survey. HSAG recommends that the MQD continue to use a mixed-mode approach (e.g., mail survey, email reminders, or web-based survey) to help yield higher response rates. An email with a direct link to the web-based survey and customized to include a provider's specific login promotes provider participation by allowing immediate and convenient access to the web-based survey. The potential for initial and follow-up distribution of the survey via provider email as opposed to only mailed paper copies would increase the likelihood of higher response rates by allowing ease of access to the web-based component of the survey.

State of Hawaii

Department of Human Services

Med-QUEST Division

2017 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

April 2018

HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

Overview

The 2017 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) 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.[1-1] 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 QI health plans and the CCS program. The QI health plans were AlohaCare QUEST Integration Plan (AlohaCare QI), Hawaii Medical Service Association QUEST Integration Plan (HMSA QI), Kaiser Foundation Health Plan QUEST Integration Plan (KFHP QI), 'Ohana Health Plan QUEST Integration ('Ohana QI), and UnitedHealthcare Community Plan QUEST Integration (UHC CP QI). 'Ohana also has held the contract for the Community Care Services (CCS) program since March 2013. CCS is a carved-out behavioral health specialty services plan for individuals who have been determined by the MQD to have a serious mental illness.

Purpose of the Report

The Code of Federal Regulations requires that states use an EQRO to prepare an annual technical report that describes how data from activities conducted, in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that managed care organizations provide.

To comply with these requirements, the MQD contracted with HSAG to aggregate and analyze the health plans' performance data across mandatory and optional activities and prepare an annual technical report. HSAG used the Centers for Medicare & Medicaid Services' (CMS') November 9, 2012, update of its External Quality Review Toolkit for States when preparing this report.[1-2]

This report provides:

- An overview of the QI and CCS programs.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

[1-2] The Centers for Medicare & Medicaid Services. External Quality Review Toolkit, November 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-toolkit.pdf. Accessed on: Mar 1, 2018.

- A description of the scope of EQR activities performed by HSAG.
- An assessment of each health plan's strengths and weaknesses for providing healthcare timeliness, access, and quality across CMS-required mandatory activities for compliance with standards, performance measures, and performance improvement projects (PIPs). The report also includes an assessment of an optional consumer satisfaction child survey.
- Recommendations for the CMOs to improve member access to care, quality of care, and timeliness of care.

Scope of EQR Activities

This report includes HSAG's analysis of the following EQR activities.

- *Review of compliance with federal and state-specified operational standards.* HSAG evaluated the health plans' compliance with State and federal requirements for organizational and structural performance. The MQD contracts with the EQRO to conduct a review of one-half of the full set of standards in Year 1 and Year 2 to complete the cycle within a three-year period. HSAG conducted on-site compliance reviews in May and June 2017. The health plans submitted documentation that covered a review period of April 1, 2016, through March 31, 2017. HSAG provided detailed, final audit reports to the health plans and the MQD in September 2017.
- *Validation of performance improvement projects (PIPs).* HSAG validated PIPs for each health plan to ensure the health plans designed, conducted, and reported projects in a methodologically sound manner consistent with the CMS protocol for validating PIPs. Each health plan submitted two state-mandated PIPs for validation. All PIPs were based on the rapid-cycle PIP framework, which includes five modules that were submitted by the health plans for each PIP, reviewed by HSAG, and used to provide feedback from HSAG to the health plans throughout the 12-month PIP cycle. HSAG assessed all PIPs for real improvements in care and services to validate the reported improvements. In addition, HSAG assessed the health plans' PIP outcomes and impacts on improving care and services provided to members. The CMOs submitted Modules 4 and 5 for each PIP at varying times throughout calendar year (CY) 2017. HSAG provided final, CMO-specific PIP reports to the health plans and the MQD in September 2017. A new round of rapid-cycle PIPs began in 2017 focused on completion of Module 1 through Module 3; however, these results will not be ready until CY 2018.
- *Validation of performance measures (PMs).* HSAG validated the HEDIS and non-HEDIS state-defined measure rates required by the MQD to evaluate the accuracy of the results. HSAG assessed the PM results and their impact on improving the health outcomes of members. HSAG conducted validation of the PM rates following the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] Compliance Audit™ [1-4] timeline, typically from January 2017 through July 2017. The final PM validation results generally reflect the measurement period of January 1, 2016, through December 31, 2016. HSAG provided final audit reports to the health plans and the MQD in July 2017.

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-4] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys.[1-5] The MQD conducted the CAHPS surveys of the QI child and Children's Health Insurance Program (CHIP) populations to learn more about member satisfaction and experiences with care. The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with chronic conditions [CCC] measurement set). The parents and caretakers of child members enrolled in the QI and CHIP program completed the surveys from February to May 2017. HSAG aggregated and produced a final report in September 2017.

Overall Summary of Health Plan Performance

Compliance Monitoring Review

CY 2017 began the second year of a three-year cycle of compliance reviews for all the QI health plans and the CCS program that included two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs, using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the CFR for six areas of review, or standards.[1-6] A pre-on-site desk review, on-site review with interview sessions, system and process demonstrations, and record reviews were conducted.

The second compliance review activity in 2017 involved HSAG's and the MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to its 2016 compliance review, which were all addressed by the end of 2016 or early 2017.

Findings, Conclusions, and Recommendations

Table 1-1 summarizes the results from the 2017 compliance monitoring reviews. This table contains high-level results used to compare 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. Health plan scores with red shading indicate performance below the statewide score.

[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-6] CY 2017 standards included the following: *Provider Selection, Subcontracts and Delegation, Credentialing, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines.*

Table 1-1—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I Provider Selection	100%	100%	100%	100%	100%	100%	**100%**
II Subcontracts and Delegation	94%	100%	56%	100%	100%	100%	**92%**
III Credentialing	94%	95%	88%	93%	91%	94%	**93%**
IV Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	94%	**99%**
V Health Information Systems	100%	100%	100%	100%	100%	100%	**100%**
VI Practice Guidelines	100%	100%	100%	100%	100%	100%	**100%**
Totals	**96%**	**97%**	**88%**	**96%**	**95%**	**96%**	**95%**

***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.

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. Three of the standards were found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—i.e., *Provider Selection*, *Health Information Systems*, and *Practice Guidelines*. The *Subcontracts and Delegation* and *Credentialing* standards were identified as having the greatest opportunity for improvement with statewide compliance scores of 92 percent and 93 percent, respectively. However, while the *Subcontracts and Delegation* standard exhibited the lowest overall performance (i.e., 92 percent), this statewide compliance score was largely driven by KFHP QI's low score (i.e., 56 percent). Conversely, lower performance on the *Credentialing* standard was consistent across all health plans, with individual health plan scores ranging from 88 percent (i.e., KFHP QI) to 95 percent (HMSA QI).

Individual health plan performance revealed the following:

- AlohaCare QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - AlohaCare QI had a total compliance score of 96 percent with four of the standards scoring 100 percent: *Provider Selection*, *Quality Assessment and Performance Improvement*, *Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.
  - AlohaCare QI was required to develop a corrective action plan (CAP) to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.
- HMSA QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - HMSA QI had a total compliance score of 97 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance*

Improvement, Health Information Systems, and *Practice Guidelines.* None of the standards or elements were noncompliant.
  - HMSA QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor HMSA's QI CAP activities until the health plan is found to be in full compliance.
- KFHP QI's performance across all standards was moderate, meeting or exceeding the statewide compliance score for four of the six standards.
  - KFHP QI had the lowest performance with a total compliance score of 88 percent and four of the standards scoring 100 percent: *Provider Selection, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines.* Three elements across the *Subcontracts and Delegation* and *Credentialing* standards were noncompliant.
  - KFHP QI's total compliance score was driven by low compliance noted in the *Subcontracts and Delegation* (56 percent) and *Credentialing* (88 percent) standards.
  - KFHP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor KFHP's QI CAP activities until the health plan is found to be in full compliance.
- 'Ohana QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - 'Ohana QI had a total compliance score of 96 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.
  - 'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana QI's CAP activities until the health plan is found to be in full compliance.
- UHC CP QI's performance across all standards was moderate, meeting or exceeding the statewide compliance score for all standards except *Credentialing*.
  - UHC CP QI had a total compliance score of 95 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines.* None of the standards or elements were noncompliant.
  - UHC CP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor UHC CP's CAP activities until the health plan is found to be in full compliance.
- 'Ohana CCS' performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards except *Quality Assessment and Performance Improvement*.
  - 'Ohana CCS had a total compliance score of 96 percent with four of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Health Information Systems,* and *Practice Guidelines.* None of the standards or elements were noncompliant.

- 'Ohana CCS was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

With the completion of these reviews, the health plans and CCS have demonstrated their structural and operational compliance and ability to provide quality, timely, and accessible services.

The QI health plans' and CCS' CAP implementation resulting from HSAG's 2016 compliance review was also monitored by HSAG and the MQD in CY 2017. All health plans successfully closed out their CAPs by February 2017, with most interventions focusing on policies, procedures, and forms. Deficiencies from the CY 2017 reviews are currently under CAPs and continue to be monitored by HSAG and the MQD.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the *2016 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5.* The audit procedures were also consistent with the CMS protocol for performance measure validation: *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[1-7] The health plans that contracted with the MQD during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit 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. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health. The measurement period was CY 2016 (January 1, 2016, through December 31, 2016), and the audit activities were conducted concurrently with HEDIS 2017 reporting.

During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 33 measures, yielding a total of 96 measure indicators, for the QI population. 'Ohana CCS was required to report on 10 measures, yielding a total of 27 measure indicators, for the CCS program. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services. These domains included:

- Access to Care
- Children's Preventive Care
- Women's Health

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Apr 17, 2018.

- Care for Chronic Conditions
- Behavioral Health
- Utilization and Health Plan Descriptive Information

Findings, Conclusions, and Recommendations

NCQA HEDIS Compliance Audit

HSAG evaluated each QI health plan's compliance with NCQA information system (IS) standards during the 2017 NCQA HEDIS Compliance Audit. All QI health plans were *Fully Compliant* with the IS standards applicable to the measures under the scope of the audit except for AlohaCare QI (IS 5.0 = *Partially Compliant*). Overall, the health plans followed the NCQA HEDIS 2016 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of *Reportable* except for two measures reported by UHC CP QI, which received a *Biased Rate* designation for the *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence* measures.

Performance Measure Results

HSAG analyzed the performance measure results for each health plan, and where applicable, HSAG compared the results to the NCQA national Medicaid HEDIS 2016 means and percentiles. For the inverse measure indicators, where a lower rate indicates better performance (i.e., *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%], Well-Child Visits in the First 15 Months of Life—0 Visits, Plan All-Cause Readmissions, Frequency of Prenatal Care—<21 Percent,* and *Ambulatory Care—ED Visits/1,000),* HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied.[1-8]

In the following figures, "N" indicates, by health plan, the total number of indicators in the QI and CCS performance measures that were compared to the HEDIS 2016 national Medicaid percentiles. Rates representing a population too small for reporting purposes (i.e., "*Not Applicable*," or *NA*) or for which comparisons to national percentiles were not appropriate, were not included in the following summary results.

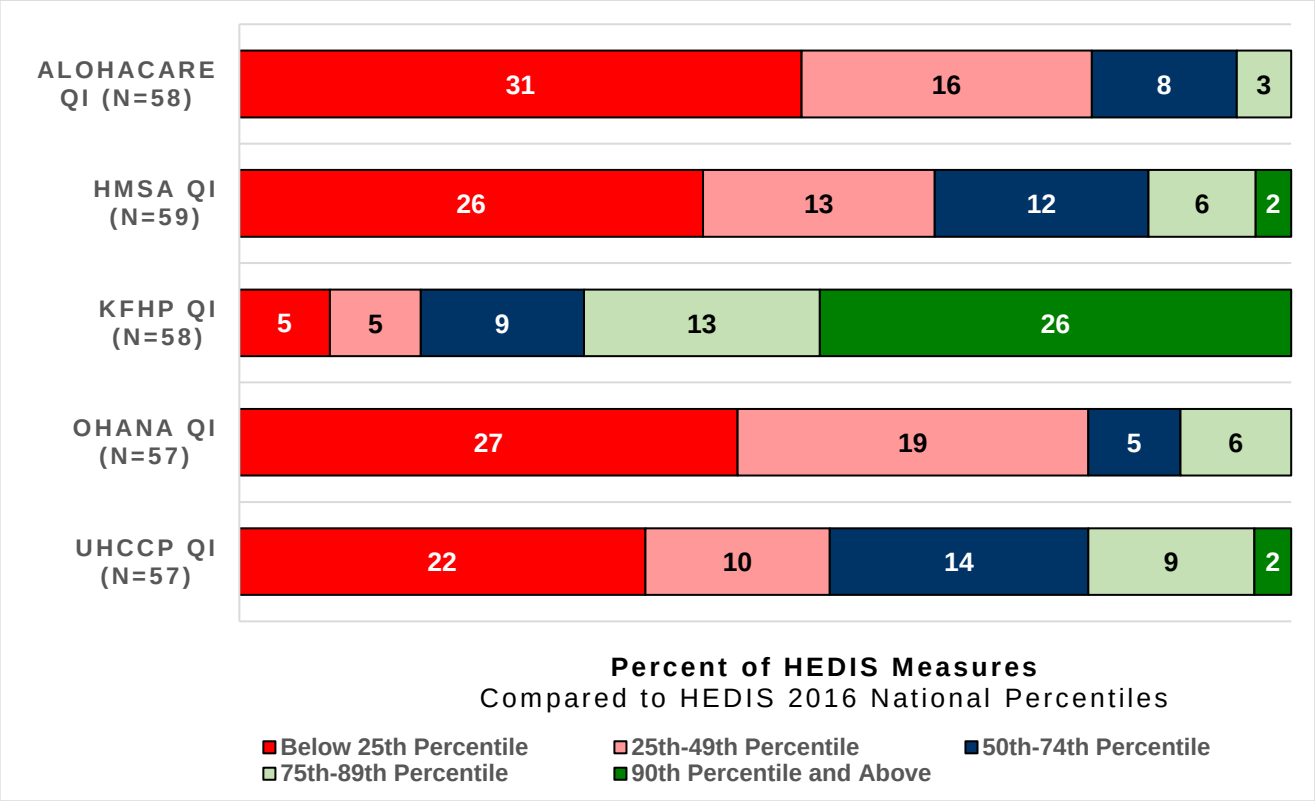
For QI health plans, HSAG validated 33 HEDIS 2017 performance measures, resulting in a total of 96 separate indicator rates reported across all audited measures, of which 60 indicators were compared to national Medicaid HEDIS 2016 percentiles.[1-9] None of the plans reported all 60 indicators. AlohaCare QI had two indicators, HMSA QI had one indicator, KFHP QI had two indicators, 'Ohana QI had three indicators, and UHC CP QI had five indicators with denominator(s) less than 30 for which valid rates could not be reported. For those indicators, the plans received an audit result of *NA* (small denominator).

[1-8] 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.

[1-9] Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate. For these reasons, some measure results are presented for informational purposes only and are not compared to national percentiles.

Figure 1-1 shows the plans' performance on those measure indicators that could be compared to the national percentiles.

Figure 1-1—Comparison of QI Measure Indicators to HEDIS Medicaid National Percentiles



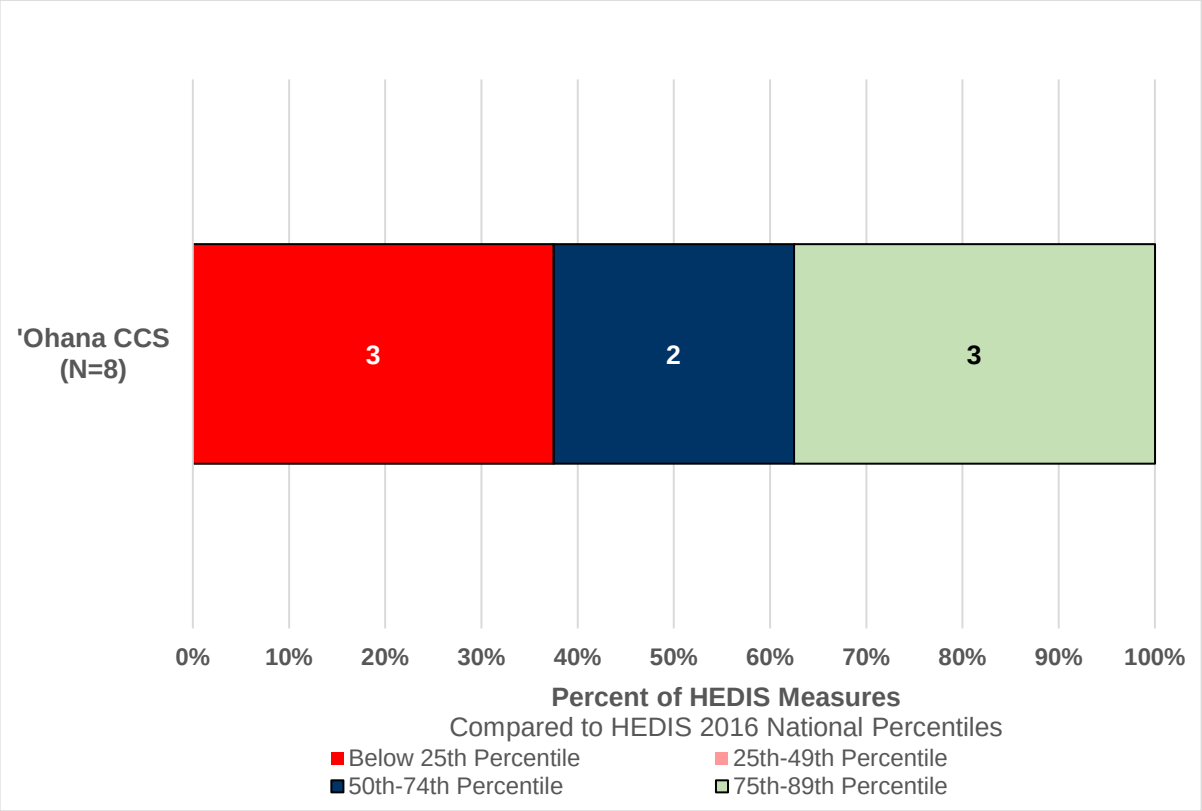
As presented in Figure 1-1, the plans were diverse in their performance. KFHP QI, the best-performing plan for HEDIS 2017, reported 26 of 58 indicators (45 percent) at or above the HEDIS 2016 national Medicaid 90th percentile, along with 13 indicators (22 percent) at or above the national 75th percentile but below the 90th percentile. UHC CP QI performed moderately with just under half of the measure rates reporting at or above the 50th percentile (i.e., 25 of 57 indicators), and about one-fifth of the measure rates reporting at or above the 75th percentile (i.e., 11 of 57 indicators). UHC CP QI and HMSA QI each had two measure rates that met or exceeded the 90th percentile. AlohaCare QI, HMSA QI, and 'Ohana QI were the lowest-performing plans compared to the national percentiles, each with more than two-thirds of their measure rates below the national 50th percentile (i.e., 47 of 58 indicators, 39 of 59 indicators, and 46 of 57 indicators, respectively). Moreover, 31 of AlohaCare QI's measure rates (53 percent), 26 of HMSA QI's measure rates (44 percent) and 27 of 'Ohana QI's measure rates (47 percent) were below the 25th percentile, indicating considerable room for improvement. Neither AlohaCare QI or 'Ohana QI had rates that met or exceeded the 90th percentile.

Additionally, all five health plans had reportable rates for 16 measures with MQD Quality Strategy targets. KFHP QI met or exceeded 12 (75 percent) of the MQD Quality Strategy targets, followed by UHC CP QI, which met or exceeded the MQD Quality Strategy targets for seven measure rates (44

percent). HMSA QI and ‘Ohana QI met or exceeded three and two of the MQD Quality Strategy targets, respectively. AlohaCare QI did not meet any of the targets. These results, in combination with overall HEDIS measure rates, suggest considerable room for improvement for AlohaCare QI, HMSA QI, and ‘Ohana QI.

Figure 1-2 shows the CCS’ performance on those measure indicators that could be compared to the national percentiles. CCS had two measures with denominators less than 30 for which valid rates could not be reported.

Figure 1-2—Comparison of CCS Measure Indicators to HEDIS Medicaid National Percentiles



As presented in Figure 1-2, ‘Ohana CCS’ program performance was strong, with five of the eight measure rates ranking at or above the 50th percentile (63 percent). The remaining three indicators fell below the 25th percentile. There is one measure in this domain with an MQD Quality Strategy target for HEDIS 2017 (i.e., *Follow-Up After Hospitalization for Mental Illness)*, and ‘Ohana CCS met or exceeded the established target, the 75th percentile.

Recommendations for improvement are presented in the plan-specific results sections of this report. In general, HSAG recommends that each plan target the lower-scoring measures/indicators for improvement. Each plan should conduct a barrier analysis to determine why plan performance was low, coupled with data analysis and drill-down evaluations of noncompliant cases.

Performance Improvement Projects

PIPs are designed as an organized way to assist health plans in assessing their healthcare processes, implementing process improvements, and improving outcomes of care. In 2016, HSAG validated two PIPs for each of the QI and CCS health plans, for a total of 12 PIPs. The five QUEST Integration plans were required by the MQD to conduct *All-Cause Readmissions* and *Diabetes Care* PIPS. The *All-Cause Readmissions* PIP topic is a key focus of the MQD's Quality Strategy. 'Ohana CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*.

The goal of HSAG's PIP validation is to ensure that the health plan and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP. In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement. To illustrate how the rapid-cycle PIP framework continued to meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-10] HSAG presented the crosswalk and new PIP framework components to CMS, and CMS agreed that with the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern PIPs within healthcare settings, a new approach was reasonable, approving HSAG's rapid-cycle PIP framework for validation of PIPs for the State of Hawaii.

For this new PIP framework, HSAG developed five modules, each with a companion guide. Each module includes validation criteria necessary for successful completion of a valid PIP. Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

- *High confidence* = the PIP was methodologically sound, achieved meaningful improvement for the SMART (specific, measurable, achievable, relevant, and time-bound) Aim measure, and the demonstrated improvement was clearly linked to the quality improvement processes conducted.
- *Confidence* = the PIP was methodologically sound; achieved meaningful improvement for the SMART Aim measure; and some of the quality improvement processes were clearly linked to the demonstrated improvement, but there was not a clear link between all quality improvement processes and the demonstrated improvement.

[1-10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Mar 1, 2018.

- *Low confidence* = (1) the PIP was methodologically sound, but improvement was not achieved for the SMART Aim measure; or (2) improvement was achieved for the SMART Aim measure, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Findings, Conclusions, and Recommendations

Health plan performance on the two PIPs continued to demonstrate the continued need for improvement around the application and documentation of the rapid-cycle PIP process, especially in intervention testing through PDSA cycles. Well-planned, appropriately executed, and clearly documented PDSA cycles are necessary to achieve a *High Confidence* level in a PIP and drive sustainable improvement.

Overall, the five QI health plans achieved the SMART Aim goal for all PIPs, except for AlohaCare QI on its *All-Cause Readmissions* PIP, which failed to meet the SMART Aim goal. These findings demonstrate that, in general, the health plans defined attainable goals as part of the rapid-cycle PIP process, and the goals were achieved during the life of the PIP.

However, while the health plans were successful in achieving the outcomes defined by the SMART Aim goals, they had considerable difficulty achieving a *High Confidence* level for most PIPs. AlohaCare QI was the only health plan that received a level of *High Confidence* for any PIPs. KFHP QI and UHC CP QI each achieved a moderate *Confidence* level for their *All-Cause Readmissions* and *Diabetes Care* PIPs, respectively, while the remaining PIPs all received an assignment of *Low Confidence* due to the inability to clearly link the interventions tested to the outcomes.

Similarly, 'Ohana CCS achieved the SMART Aim goal for both of its PIPs, demonstrating that the health plan defined attainable goals as part of its rapid-cycle PIP process and that the goals were achieved during the life of the PIP. However, both PIPs received an assessment of *Low Confidence* due to the inability to clearly link the interventions tested to the outcomes.

The health plans' performance regarding PIPs suggested opportunities for improvement in many areas of the rapid-cycle PIP process, such as ensuring a sound measurement methodology for the PIP outcomes; maintaining the integrity of approved measurement methodology throughout the PIP process; identifying the true root causes of barriers to improvement; and planning and executing effective PDSA cycles to test and refine interventions that will result in meaningful, sustained, and spreadable improvement strategies. Many of these opportunities for improvement applied consistently across all health plans and topics. Specific recommendations related to improving PIP performance are detailed in the plan-specific results sections of this report. In general, HSAG recommends that the health plans seek technical assistance as needed to further develop their capacity to apply sound improvement science in the rapid-cycle PIP process.

CAHPS—Child Survey

The CAHPS health plan surveys are standardized survey instruments which measure members' satisfaction levels with their healthcare. For 2017, HSAG administered the Child Medicaid Health Plan

Survey instrument (without the CCC measurement set) to child Medicaid and CHIP members of the QI health plans who met age and enrollment criteria. All members of sampled child Medicaid and CHIP members completed the surveys from February to May 2017 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.[1-11] 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

Table 1-2 presents the question summary rates and global proportions for the QI Program aggregate compared to the 2017 NCQA national child Medicaid average, as well as the results from HSAG's comparison to NCQA's HEDIS benchmarks.[1-12, 1-13]

Table 1-2—2017 QUEST Integration Child CAHPS Results

	QI Program Aggregate	NCQA Comparison
Global Ratings		
Rating of Health Plan	69.1%	★★★
Rating of All Health Care	65.0%	★★★★
Rating of Personal Doctor	74.1%	★★★★
Rating of Specialist Seen Most Often	72.9%	★★★★★
Composite Measures		
Getting Needed Care	82.8%	★★
Getting Care Quickly	86.4%	★
How Well Doctors Communicate	94.4%	★★★★
Customer Service	86.9%	★
Shared Decision Making	82.7%	—

[1-11] Please note that administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.0H Child Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.

[1-12] The QI Program aggregate results were derived from the combined results of the five participating QI health plans.

[1-13] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

	QI Program Aggregate	NCQA Comparison
Individual Item Measures		
Coordination of Care	83.8%	★★
Health Promotion and Education	75.8%	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.
(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.
Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th
★★ 25th–49th ★ Below 25th

Comparison of the QI Program aggregate, AlohaCare QI, HMSA QI, KFHP QI, ‘Ohana QI, and UHC CP QI scores to the 2016 NCQA national child Medicaid average revealed the following:

- The QI Program aggregate scores were at or above the NCQA national child Medicaid average on six measures: *Rating of Health Plan, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.
- AlohaCare QI scored at or above the NCQA national child Medicaid average on three measures: *Customer Service, Shared Decision Making,* and *Health Promotion and Education.*
- HMSA QI scored at or above the NCQA national child Medicaid average on nine measures: *Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.
- KFHP QI scored at or above the NCQA national child Medicaid average on 11 measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.
- ‘Ohana QI scored at or above the NCQA national child Medicaid average on three measures: *Rating of Specialist Seen Most Often, Shared Decision Making,* and *Health Promotion and Education*.
- UHC CP QI scored at or above the NCQA national child Medicaid average on five measures: *Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.

Comparison of the QI Program aggregate to the 2017 NCQA HEDIS benchmarks for accreditation revealed the following:

- The QI Program scored at or above the 75th percentile on four measures, with one of these measures scoring at or above the 90th percentile: *Rating of All Health Care, Rating of Personal Doctor, How Well Doctors Communicate,* and *Rating of Specialist Seen Most Often,* respectively. Four measures scored below the 50th percentile, two of which scored below the 25th percentile: *Getting Needed Care, Coordination of Care, Getting Care Quickly, and Customer Service,* respectively. Of the three MQD Quality Strategy targets, only the QI Program’s member satisfaction rating met or exceeded the 75th percentile for *How Well Doctors Communicate*.

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. Table 1-3 presents the question summary rates and global proportions for the Hawaii CHIP population.

Table 1-3—Comparison of 2017 CHIP CAHPS Results

	CHIP Aggregate Ratings	NCQA Comparison
Global Ratings		
Rating of Health Plan	72.2%	★★★★★
Rating of All Health Care	69.1%	★★★★★
Rating of Personal Doctor	73.8%	★★★★★
Rating of Specialist Seen Most Often	72.1%	★★★★★
Composite Measures		
Getting Needed Care	82.3%	★
Getting Care Quickly	87.1%	★★
How Well Doctors Communicate	95.5%	★★★★★
Customer Service	85.2%	★
Shared Decision Making	80.3%	—
Individual Item Measures		
Coordination of Care	82.5%	★
Health Promotion and Education	79.7%	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.
(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.

Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th
★★ 25th–49th ★ Below 25th

Comparison of the CHIP scores to the 2016 NCQA national child Medicaid average revealed the following:

- Hawaii's CHIP scored at or above the NCQA national child Medicaid average on six measures: *Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making,* and *Health Promotion and Education*.

Comparison of the CHIP scores to the 2017 NCQA national child Medicaid average revealed the following:

- The Hawaii CHIP population scored at or above the 90th percentile on five measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *How Well Doctors Communicate*. The four remaining ratings fell below the 50th percentile, with three of these measures scoring below the 25th percentile: *Getting Care Quickly,*

Getting Needed Care, *Coordination of Care*, and *Coordination of Care*, respectively. Of the three MQD Quality Strategy targets, the Hawaii CHIP population's member satisfaction rating met or exceeded the 75th percentile on two measures: *Rating of All Health Care* and *How Well Doctors Communicate*.