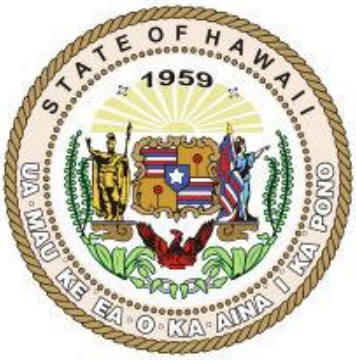
State of Hawaii

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

HSAG HEALTH SERVICES ADVISORY GROUP

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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]

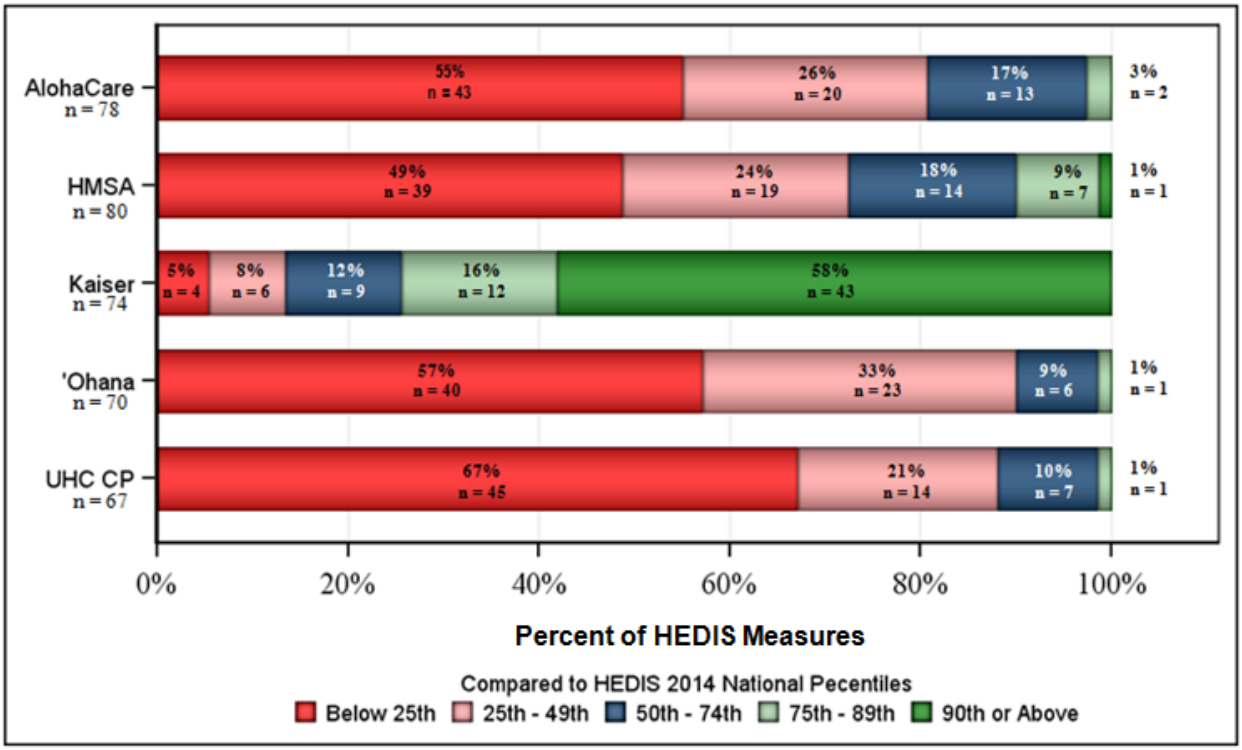
The "n" in the following figures indicates, by health plan, the number of indicators in the non-ABD, ABD, and CCS performance measures that fell within the designated percentile range compared to the HEDIS 2014 national Medicaid percentiles. Rates representing a population too small for reporting purposes 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

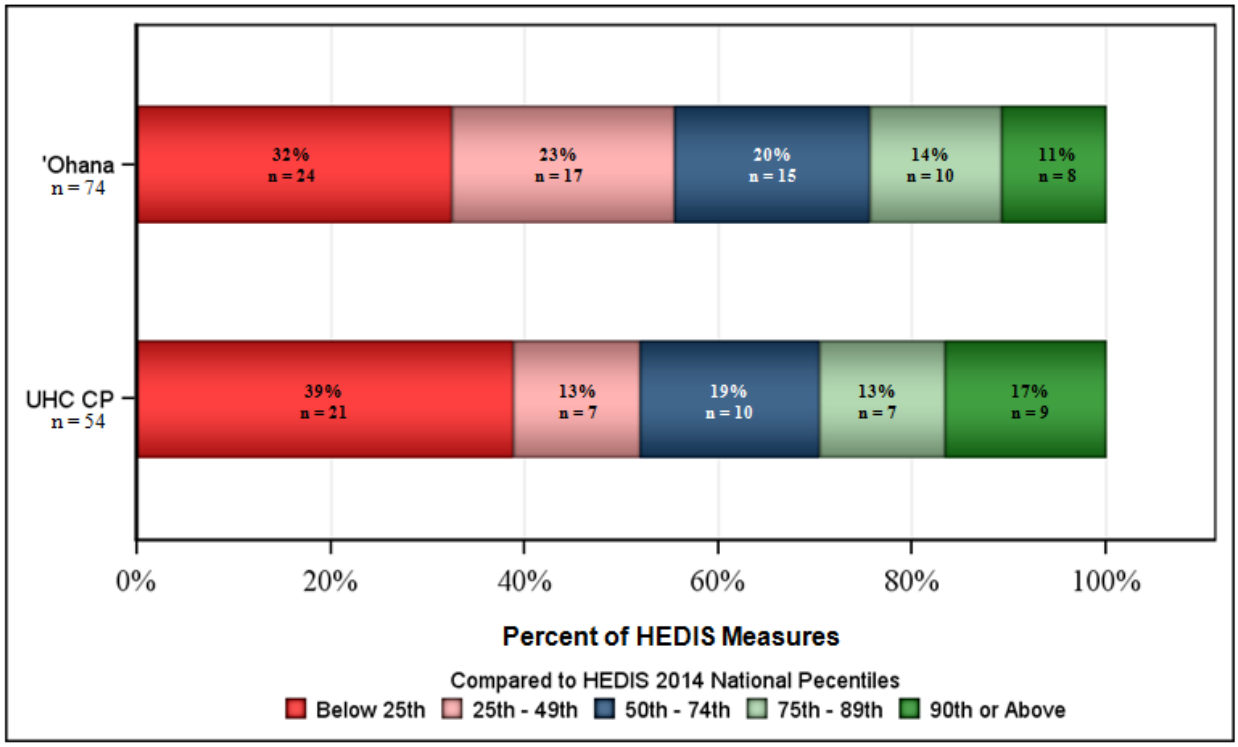


Please note: Percentages may not total 100% due to rounding.

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



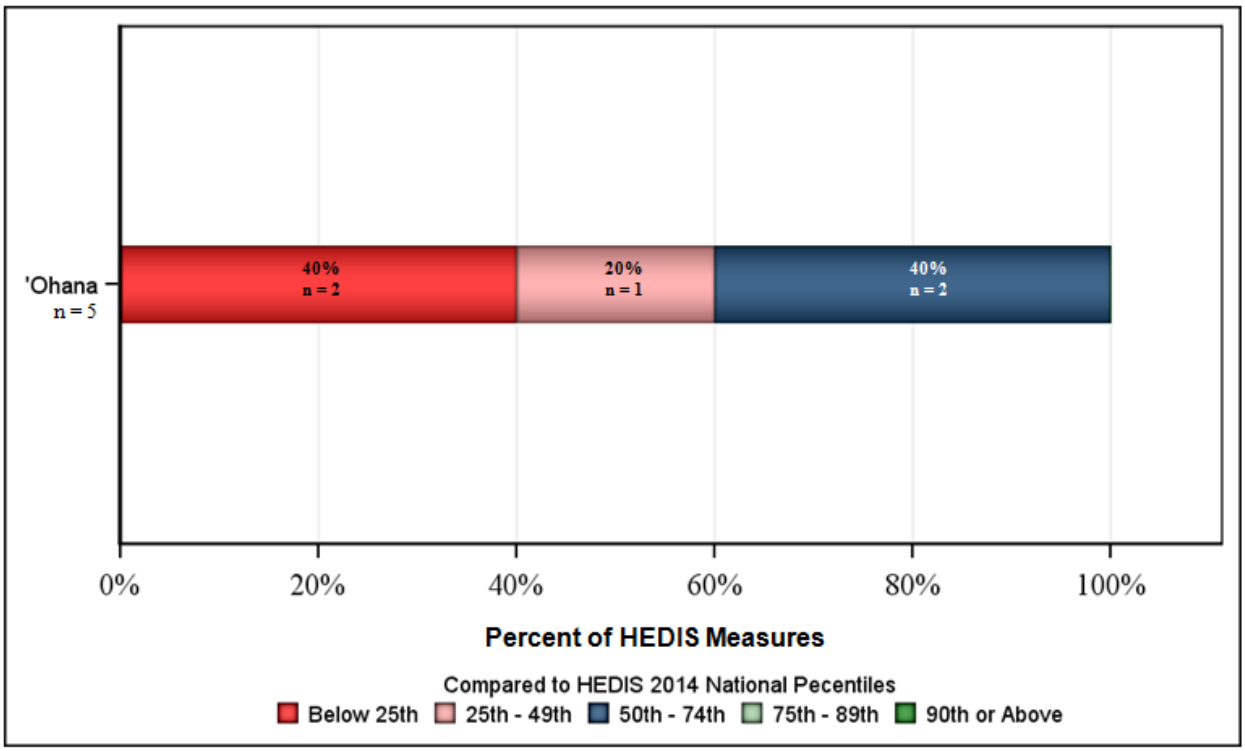
Please note: Percentages may not total 100% due to rounding.

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

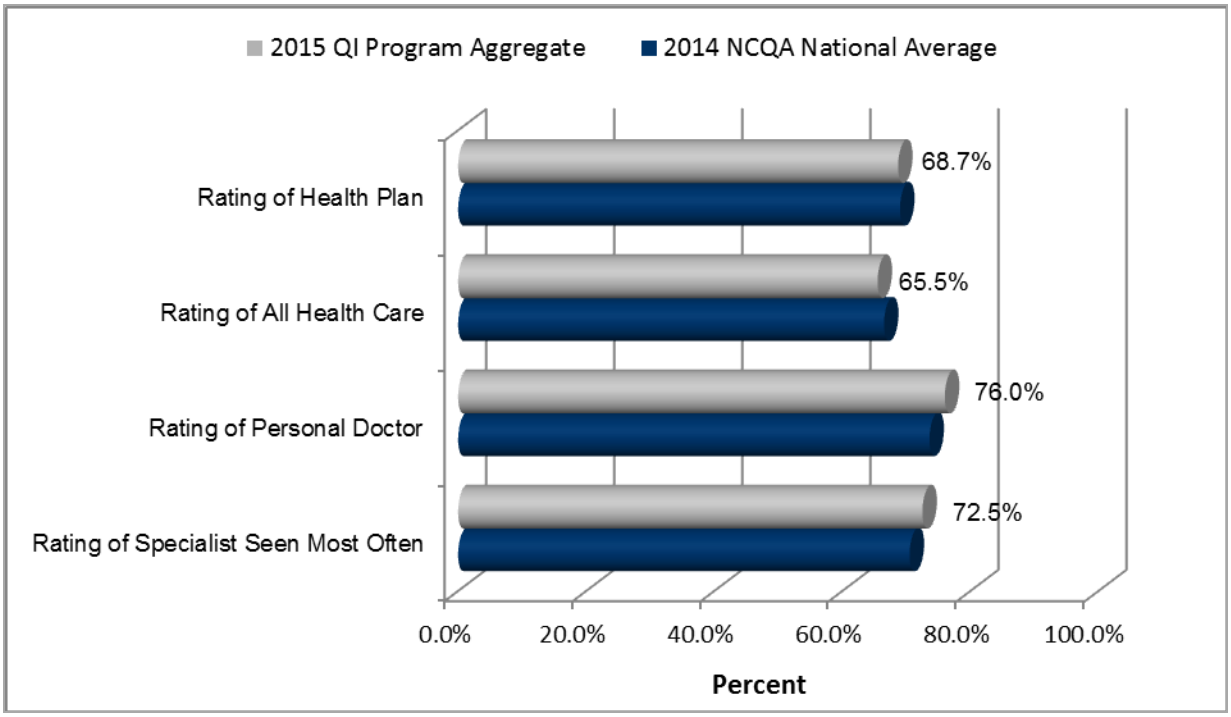
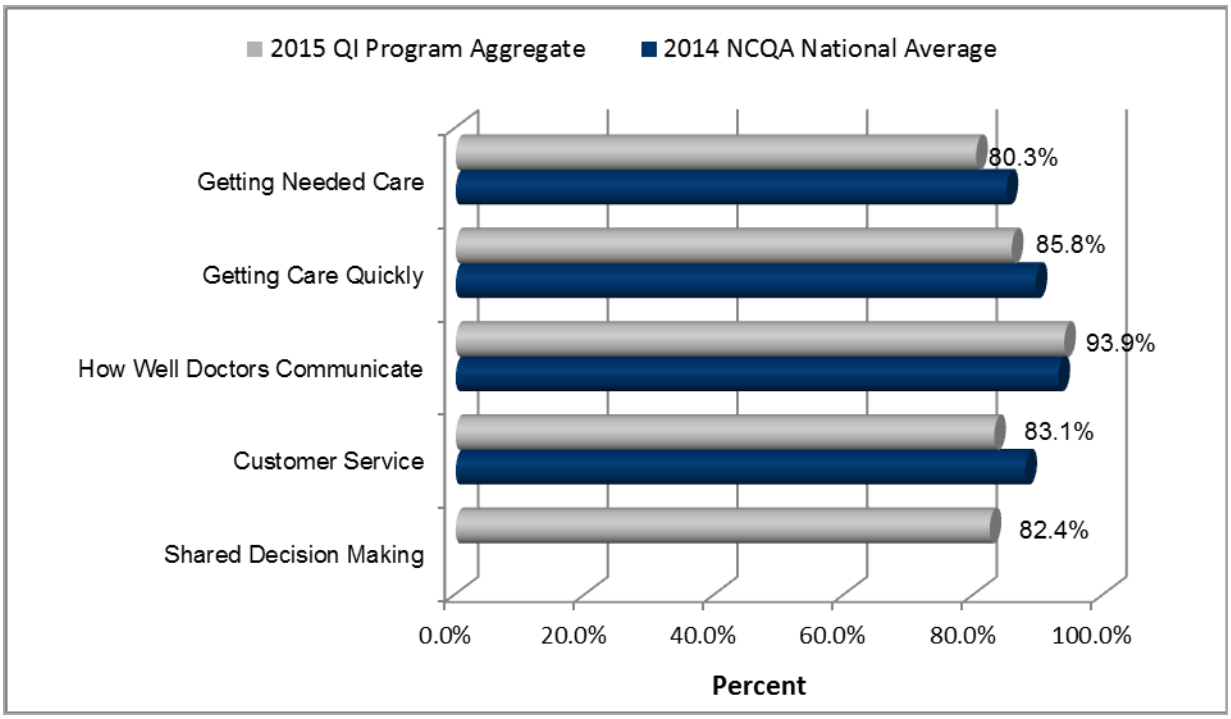


Figure 1-5 depicts the top-box scores for the statewide QI Program aggregate and the 2014 NCQA national child Medicaid average for each of the composite measures.

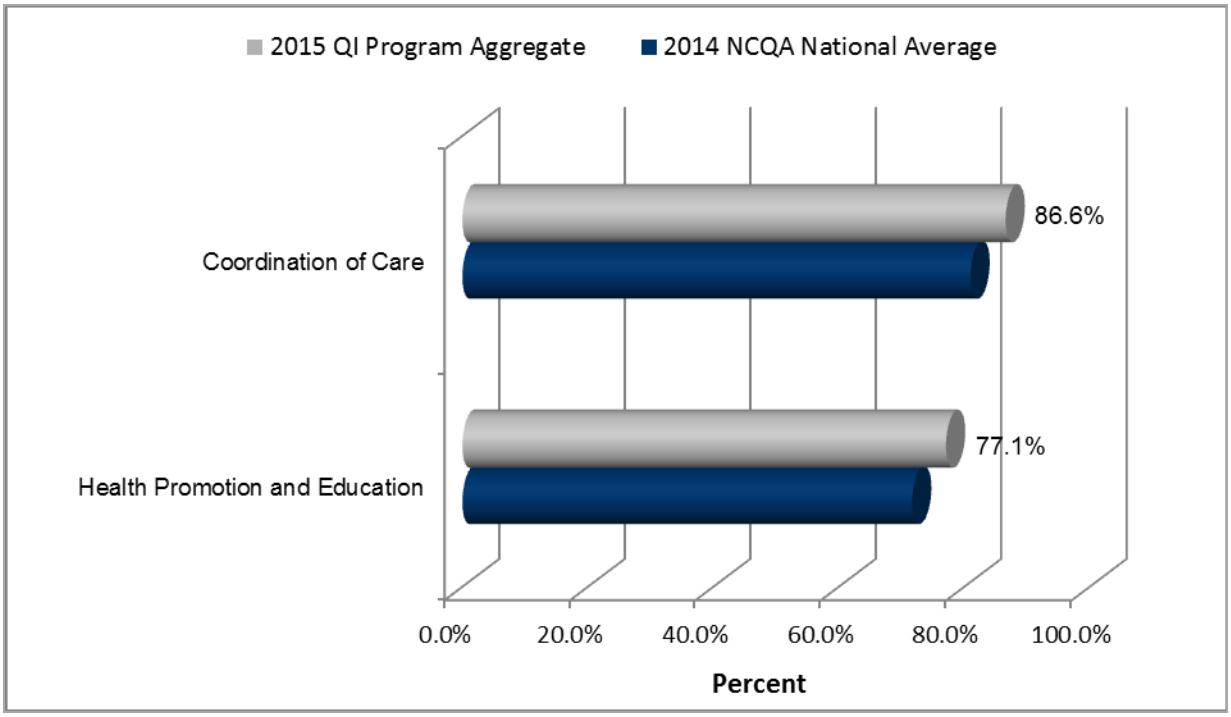
Figure 1-5—QI Program Aggregate: Composite Measures



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

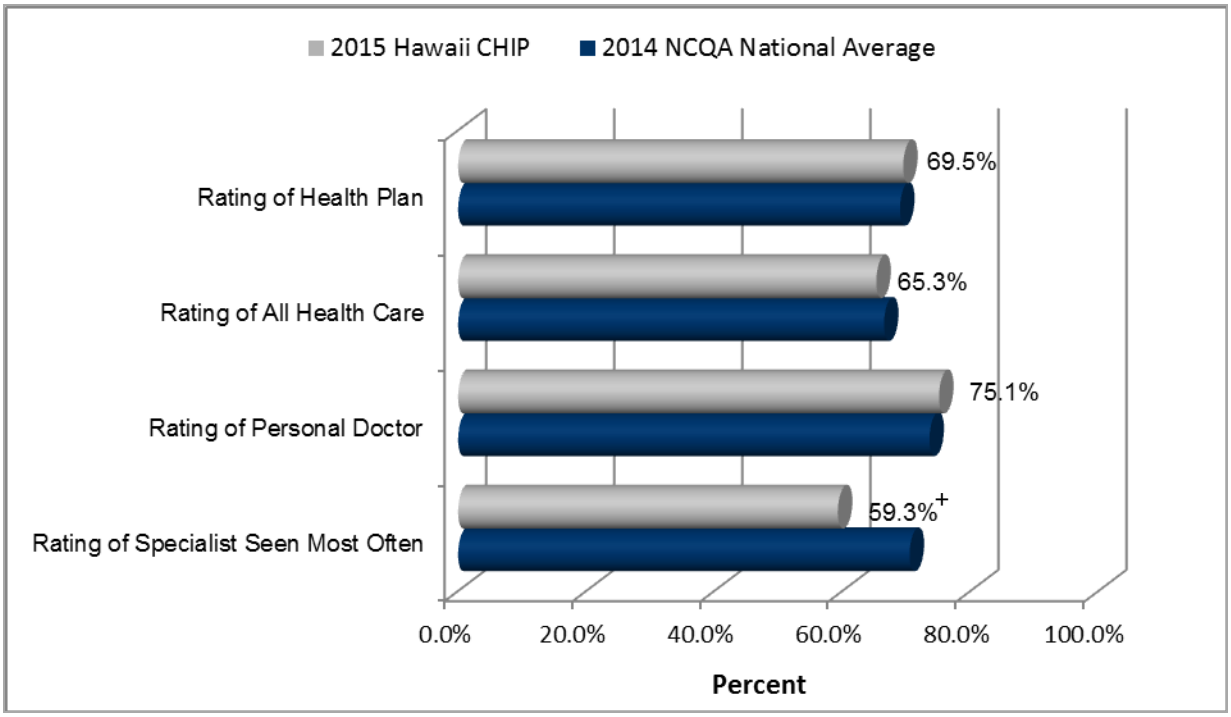


As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparative purposes. As compared to the 2014 NCQA national child Medicaid average, the following results were noted for the CHIP population:

- 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.

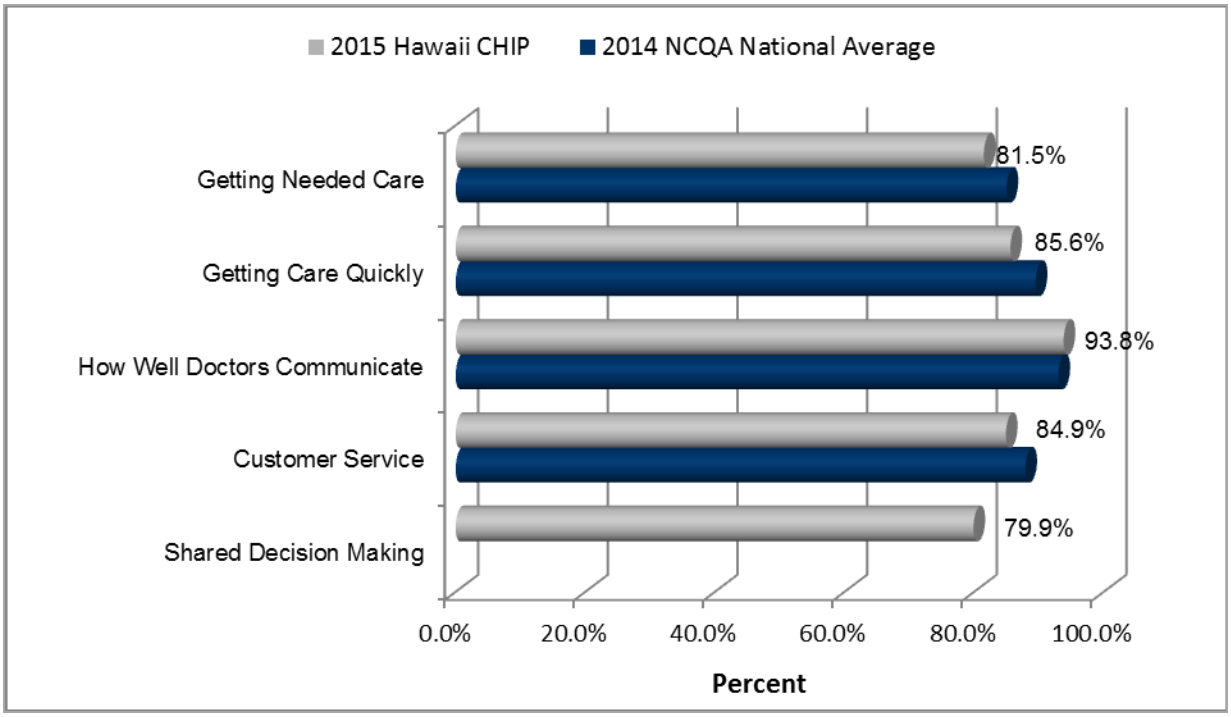
Figure 1-7—CHIP: Global Ratings



+ 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.

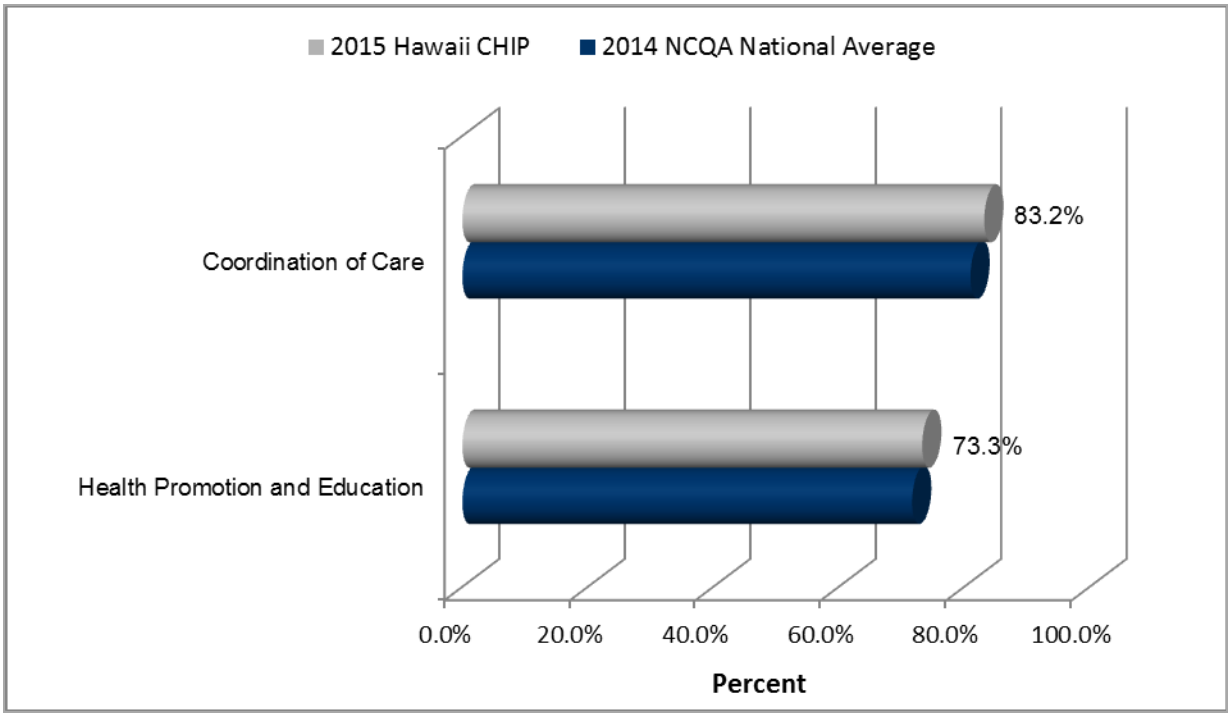
Figure 1-8—CHIP: Composite Measures



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.

Overview of the Hawaii Medicaid Service Delivery System

The Hawaii Medicaid Program

Medicaid covers more than 324,000[2-1] individuals in the State of Hawaii. The MQD, the division of the Department of Human Services responsible for the overall administration of the State's Medicaid managed care program, has as its mission statement, "To develop and administer high-quality health care programs serving all eligible Hawaii residents." The Hawaii QUEST program is designed to provide:

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

Over the past year, Hawaii's Medicaid program has undergone significant transition. Formerly, Hawaii's service delivery system used two main program and health plan types to enroll members and provide care and services. Most Medicaid recipients received primary and acute care service coverage through the QUEST program, a managed care model operating under an 1115 research and demonstration waiver since 1994. Members had a choice of five QUEST health plans. [The QUEST program also included the State's Child Health Insurance Program (CHIP) enrollees, operating as a Medicaid expansion program.] Beginning February 1, 2009, Medicaid-eligible individuals 65 years of age and older and individuals certified as blind or disabled were enrolled in Hawaii's QExA Medicaid managed care program, receiving primary and acute services as well as long-term services and supports through a choice of two health plans.

As part of its overall improvement and realignment strategy, the MQD implemented the QUEST Integration (QI) program. The QI program is a melding of several previous programs—QUEST, QUEST-ACE, QUEST-Net, and QExA—into one statewide program model that provides managed healthcare services to Hawaii's Medicaid/CHIP population. Each of the QI health plans administer all benefits to enrolled members, including primary, preventive, acute, and long-term services and supports. The goals of the QI program are to:

- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating programs and benefits.
- Align the program with the Affordable Care Act (ACA) of 2010.

[2-1] All Medicaid enrollment statistics cited in this section are as of August 2015, as cited in *Hawaii Medicaid Managed Care Enrollment,* available at: http://www.med-quest.us/PDFs/queststatistics/EnrollmentReports2015.pdf Accessed on: October 14, 2015.

- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCPs).
- Expand access to home and community-based services (HCBS) and allow members choice between institutional services and HCBS.
- Maintain a managed care delivery system that assures access to high quality, cost-effective care that is provided, whenever possible, in the members' community.
- Establish contractual accountability among the State, the health plans, and healthcare providers.
- Continue the predictable and slower rate of expenditure growth associated with managed care.
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to a more appropriate utilization of the healthcare system.

The MQD awarded contracts to five health plans, which became operational as QI program plans effective January 1, 2015:

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

All QI health plans provide Medicaid services statewide (i.e., on all islands) except for Kaiser, which chose to focus efforts on the islands of Oahu and Maui. In addition to the QI health plans, Hawaii's Medicaid program includes the Community Care Services (CCS) behavioral health carve-out, a program providing managed specialty behavioral health services for Medicaid individuals with a serious mental illness. 'Ohana Health Plan was awarded the CCS contract and has been operational statewide since March 1, 2013.

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

The QUEST Integration Health Plans

AlohaCare

AlohaCare is a nonprofit health plan founded in 1994 by Hawaii's community health centers. As one of the largest health plans in Hawaii, and administering both Medicaid and Medicare health plan products, AlohaCare serves nearly 64,000 Medicaid enrollees in its QI health plan and also provides a dual special needs plan for dually eligible Medicare and Medicaid beneficiaries. AlohaCare contracts with a large network of providers statewide, emphasizing prevention and primary care. AlohaCare works very closely with 14 community health centers and the Queen Emma clinics to support the needs of the underserved, medically fragile members of Hawaii's communities on all of the islands.

Hawaii Medical Service Association (HMSA)

HMSA, an independent licensee of the Blue Cross and Blue Shield Association, is a nonprofit health plan established in Hawaii in 1938. Administering Medicaid, Medicare Advantage, Health Insurance Marketplace, and commercial health plans, HMSA is the largest provider of healthcare coverage in the State and the largest QI plan, serving over 151,000 enrolled Medicaid members. The vast majority of Hawaii's doctors, hospitals, and other providers participate in HMSA's network. HMSA has been a Medicaid contracted health plan since 1994.

Kaiser Permanente Hawaii

Established by Henry J. Kaiser in Honolulu in 1958, Kaiser's service delivery in Hawaii is based on a relationship between the Kaiser Permanente Health Plan and the Hawaii Permanente Medical Group of physicians and specialists. With its largely "staff-model" approach, Kaiser operates clinics on several islands and a medical center on Oahu, with additional hospitals and specialists participating through contract arrangements. Kaiser administers Medicaid, Medicare Advantage, Health Insurance Marketplace, and commercial health plans, and provides care to more than 28,600 enrolled Medicaid members on the islands of Maui and Oahu through the Kaiser QI health plan.

'Ohana Health Plan

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc., a subsidiary of WellCare Health Plans, Inc., which provides managed care services exclusively for government-sponsored healthcare programs, with Medicaid and Medicare Advantage health plans. 'Ohana began operating in Hawaii on February 1, 2009, initially as a QExA plan, then in July 2012 also as a QUEST plan. 'Ohana Health Plan currently provides services to almost 41,000 QI enrollees.

UnitedHealthcare Community Plan

UHC CP is offered by UnitedHealthcare Insurance Company, one of the largest Medicaid health plan providers in the nation. Providing care to more than 39,000 QI members in Hawaii, UHC CP also administers Medicare Dual Special Needs Plans and commercial health plans. UHC CP initially began operating as a QExA health plan in Hawaii on February 1, 2009, and then also as a QUEST plan on July 1, 2012.

The Community Care Services Program

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

The State's Quality Strategy

In keeping with its transition to QI, the MQD undertook a major revision of its quality strategy to align with the new program goals, the National Quality Strategy, and the requirements of the ACA.

The revised strategy was forwarded for CMS review and comment and, as of the completion of this report, was not yet ready for public comment. Updated information about the Hawaii Quality Strategy will be included in the annual report next year.

The MQD continues to make strides in its quality initiatives and transparent public reporting. As examples:

- The MQD requires optional as well as mandatory activities in HSAG's scope of work as the EQRO for the State of Hawaii Medicaid program: compliance monitoring and corrective action follow-up evaluation, performance measure validation and HEDIS audits, validation of performance improvement projects, child CAHPS survey and an additional child CHIP member survey, provider survey, and technical assistance to the MQD and the health plans.
- The MQD promotes transparency through public reporting and empowering member involvement in health plan choice. The MQD is preparing to launch new health plan performance evaluations (e.g., report cards and dashboards) on the MQD website beginning in fall 2015. In addition to the EQRO annual technical report, which has been posted on this website annually for years, the MQD has developed charts and graphs that provide information on various health plan performance measurements and quality results related to members, providers, behavioral health services, service coordination, and utilization of Medicaid services.

3. Plan-Specific Results, Conclusions, and Recommendations

Introduction

This section of the report describes the results of HSAG's 2015 EQR activities and conclusions as to the strengths and weaknesses of each health plan about the quality and timeliness of, and access to, care furnished by the Hawaii Medicaid health plans serving the QUEST Integration members. Additionally, recommendations are offered to each plan to facilitate continued quality improvement in the Medicaid program.

Appendix A of this report contains detailed information about the methodologies used to conduct each of the 2015 EQR activities. It also includes the objectives, technical methods of data collection and analysis, descriptions of data obtained, and descriptions of scoring terms and methods. In addition, a complete, detailed description of each activity conducted and the results obtained appear in the individual activity reports prepared by HSAG for the health plans and the MQD.

Compliance Monitoring Review

The 2015 Hawaii compliance monitoring review activities included (1) a review of select standards for the CCS plan, and (2) follow-up reviews of the health plans' corrective actions implemented as a result of the 2014 compliance reviews.

CCS Compliance Review

CCS was the only plan that had an on-site review of compliance in 2015, in order to bring the plan into the same three-year review cycle as the QI plans. The QI plans (formerly QUEST and QExA) had this same set of standards reviewed in 2013. Table 3-1 illustrates the compliance review results for CCS.

Table 3-1—CCS Compliance Review Standards and Scores

Standard #	Standard Name	2015 'Ohana CCS
I	Member Rights and Protections and Member Information	**100%**
II	Member Grievance System	**89%**
III	Access and Availability	**100%**
IV	Coverage and Authorization	**94%**
V	Coordination and Continuity of Care	**100%**
	Total Compliance Score:	**95%**

CCS had an overall score of 95 percent, with three of the standard areas scoring 100 percent: Member Rights and Protections and Member Information, Access and Availability, and Coordination and Continuity of Care. CCS had findings in the other two standard areas, scoring 89 percent in the Member Grievance System standard, and 94 percent in the Coverage and Authorization standard. CCS was required to develop and implement a corrective action plan to address the findings in these two areas. CCS' CAP was reviewed and approved by the MQD and HSAG, and follow-up monitoring occurred on the implementation of the corrections. CCS was found to have met the intent of the standards in the CAP areas by July 2015. CCS had addressed the findings as follows:

Member Grievance System Standard

- Revised its grievance system policies and procedures to include all notice of action (NOA) requirements and to correctly reflect the types of resolutions addressed by a State-level grievance review.
- Implemented use of the MQD-developed standardized NOA template.

- Implemented improvements in monitoring to ensure timeliness of NOAs following a denial decision.
- Revised its service authorization policies and procedures to clarify that the member also receives the NOA, and that members are notified of the right to file a grievance if disagreeing with the health plan's extension of a service authorization decision time frame.
- Revised its pharmacy appeals policy and procedure to reflect the availability of a 14-day extension for both standard and expedited appeals.
- Revised and clarified the member grievance system information contained in the provider manual.

Coverage and Authorization Standard

- Revised policies and the provider manual to ensure consistent and accurate information is provided regarding service authorization decisions.
- Revised provider manual information to clarify requirements for payment and provision of emergency and poststabilization services.
- Updated coding for its automated reporting to the MQD to ensure correct data were pulled to demonstrate timeliness of service authorization decisions.

Health Plan Follow-up CAP Reviews

In 2015, HSAG performed follow-up monitoring of the health plans' implementation of their 2014 CAPs. HMSA and UHC CP did not have compliance review findings requiring a CAP during 2014; therefore, these two plans are not included in this discussion. For AlohaCare, Kaiser, and 'Ohana, although there were other assorted findings across the plans, all had findings regarding implementation of the Affordable Care Act requirements related to obtaining and reporting provider disclosure information. Alongside HSAG's follow-up reevaluation, the MQD simultaneously reviewed policies and procedures, and met with the plans to provide additional technical assistance and direction, and to design the system and reporting specifications for the provider disclosure information. The MQD and HSAG collaborated on the findings from these reviews and coordinated communication to the health plans on any next steps required of them.

Following are summaries of each health plan's compliance review CAP follow-up results.

AlohaCare

Results

AlohaCare implemented corrective actions in the areas of Subcontracts and Delegation, and Credentialing as follows:

- Developed and implemented an electronic database (IntelliCred) as an effective mechanism for tracking all subcontracts/agreements (with providers, delegates, and other health plan vendors) to ensure that agreements did not lapse and that all provider subcontractors' credentialing and disclosure information was captured.
- Ensured ongoing monitoring of subcontractors' performance.
- Through organizational restructuring, ensured that the processes between the Provider Relations and Quality Improvement departments were coordinated, as contract renewal cycles and recredentialing cycles differ.
- Ensured that its disclosure form included fields to collect all required information.

Conclusions and Recommendations

AlohaCare successfully addressed all CAP actions and was found in substantial compliance with the requirements. The MQD continues to provide technical assistance to and monitoring of AlohaCare on the completeness, accuracy, and timely submission of its provider disclosure information. There were no continuing recommendations.

Kaiser

Results

Kaiser implemented corrective actions in the areas of Subcontracts and Delegation, Credentialing, and Quality Assessment and Performance Improvement, as follows:

- Ensured that its agreements with providers and subcontractors included the requirements and time frames for notifying the health plan and the MQD of all breaches of confidential information.
- Implemented a process and procedures to ensure that credentialing, recredentialing, and contracting activities meet the requirements to obtain full disclosure statements and business transaction disclosures as required from its providers.
- Provided electronic disclosure information to the MQD in the format required.
- Ensured that its disclosure form includes fields to collect all required information.
- Implemented mechanisms for ensuring that QUEST Integration-specific requirements are included and accurately represented in its quality improvement and utilization management program descriptions and work plans.

Conclusions and Recommendations

Kaiser successfully addressed all CAP actions and was found in substantial compliance with the requirements. The MQD continues to provide technical assistance to and monitoring of Kaiser on the completeness, accuracy, and timeliness of its submission of provider disclosure information. There were no continuing recommendations.

'Ohana

Results

'Ohana implemented corrective actions in the area of Credentialing, specifically for the standards related to provider disclosure requirements, as follows:

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

Conclusions and Recommendations

'Ohana successfully addressed this CAP action and was found in substantial compliance with the requirements. The MQD continues to provide technical assistance to and monitoring of 'Ohana on the completeness, accuracy, and timeliness of its submission of provider disclosure information. There were no continuing recommendations.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

This section reports results of the 2015 NCQA HEDIS Compliance Audits and performance measure validation for the QUEST, QExA, and CCS health plans. Also presented in this section are the actual HEDIS and non-HEDIS performance measure rates attained by each health plan on the required performance measures validated by HSAG, with comparisons to the NCQA national Medicaid HEDIS 2014 percentiles and to the previous year's rates, where applicable.

Measure rates reported by the health plans but not audited by HSAG in 2014 are not presented within this report and were not compared to this year's results. Additionally, certain measures do not have applicable benchmarks. For these reasons, HEDIS 2014 Rate, Percentage Point Change, and 2015 Performance Level values are denoted with a double-dash (--) within the tables below for these measures.

Three measures, *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (IET), *Medication Management for People With Asthma* (MMA), and *Enrollment by Product Line* (ENP) were reported by the plans with multiple rate stratifications. For the purposes of this report, only the *Initiation of AOD Treatment* and *Engagement of AOD Treatment* indicators are presented for IET, only the *Medication Compliance 50%* and *Medication Compliance 75%* indicators are presented for MMA, and only the age range stratified indicators (*0-19 years, 20-44 years,* etc.) are presented for ENP.

The health plan results tables show the current year's performance for each HEDIS measure compared to the prior year's rate and the performance level relative to the NCQA national Medicaid HEDIS 2014 percentiles. The performance level column illustrated in the tables rates the health plans' performance as follows:

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

For measure rates reported by the plans and audited by HSAG in both 2014 and 2015 (i.e., measurement years 2013 and 2014), statistical significance testing was performed to determine if the changes in rates from one year to the next were significant. These results are presented in the column, "Percentage Point Change." The percentage point change is presented as a + or -. Statistically significant improvement is represented in **green** and statistically significant decline is represented in **red**.

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

Table 3-2 presents the non-ABD, ABD, and CCS HEDIS measures and CCS non-HEDIS measures included in this report along with their abbreviations and an indication of whether the measure was collected and calculated using an administrative (admin) or hybrid methodology.

Table 3-2—Validated HEDIS Measures and Abbreviations

	Measure Name	Non-ABD	ABD	CCS	Methodology
1	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*	√	√	√	Admin
2	*Adolescent Well-Care Visits (AWC)*	√	√		Hybrid
3	*Adult BMI Assessment (ABA)*	√	√		Hybrid
4	*Adults' Access to Preventive/Ambulatory Health Services (AAP)*	√	√		Admin
5	*Ambulatory Care (AMB)*	√	√		Admin
6	*Annual Monitoring for Patients on Persistent Medications (MPM)*	√	√		Admin
7	*Antidepressant Medication Management (AMM)*	√	√		Admin
8	*Behavioral Health Assessment (BHA)**			√	Admin
9	*Breast Cancer Screening (BCS)*	√	√		Admin
10	*Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)*			√	Admin
11	*Care for Older Adults (COA)***		√		Hybrid
12	*Cervical Cancer Screening (CCS)*	√	√		Hybrid†
13	*Childhood Immunization Status (CIS)*	√	√		Hybrid†
14	*Children and Adolescents' Access to Primary Care Practitioners (CAP)*	√	√		Admin
15	*Chlamydia Screening in Women (CHL)*	√	√		Admin
16	*Colorectal Cancer Screening (COL)***	√	√		Hybrid†
17	*Comprehensive Diabetes Care (CDC)*	√	√		Hybrid†

Table 3-2—Validated HEDIS Measures and Abbreviations					
	Measure Name	Non-ABD	ABD	CCS	Methodology
18	*Controlling High Blood Pressure (CBP)*	√	√		Hybrid
19	*Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)*			√	Admin
20	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*			√	Admin
21	*Enrollment by Product Line (ENP)*	√	√	√	Admin
22	*Follow-Up After Hospitalization for Mental Illness (FUH)*	√	√	√	Admin
23	*Follow-Up of Care for Children Prescribed ADHD Medication (ADD)*	√	√		Admin
24	*Follow-Up with Assigned PCP Following Hospitalization for Mental Illness (FUP)**			√	Admin
25	*Frequency of Ongoing Prenatal Care (FPC)*	√	√		Hybrid†
26	*Human Papillomavirus Vaccine for Female Adolescents (HPV)*	√	√		Hybrid†
27	*Immunizations for Adolescents (IMA)*	√	√		Hybrid†
28	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*	√	√	√	Admin
29	*Inpatient Utilization—General Hospital/Acute Care (IPUA)*	√	√		Admin
30	*Medication Management for People With Asthma (MMA)*	√	√		Admin
31	*Medication Reconciliation Post-Discharge (MRP)***		√		Hybrid
32	*Mental Health Utilization (MPT)*	√	√	√	Admin
33	*Persistence of Beta Blocker Treatment After a Heart Attack (PBH)*	√	√		Admin
34	*Pharmacotherapy Management of COPD Exacerbation (PCE)*	√	√		Admin
35	*Plan All-Cause Readmissions (PCR)***	√	√	√	Admin
36	*Prenatal and Postpartum Care (PPC)*	√	√		Hybrid
37	*Use of Appropriate Medications for People With Asthma (ASM)*	√	√		Admin
38	*Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)*		√		Admin
39	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	√	√		Hybrid
40	*Well-Child Visits in the First 15 Months of Life (W15)*	√	√		Hybrid†

Table 3-2—Validated HEDIS Measures and Abbreviations					
	Measure Name	Non-ABD	ABD	CCS	Methodology
41	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	√	√		Hybrid†

**These measures are state-specified, non-HEDIS measures.*
***These measures were not Medicaid measures. The MQD required the PCR measure to be reported applying the Medicare weighting tables for the ABD and CCS populations and the Commercial weighting tables for the non-ABD population.*
†Kaiser received approval from the MQD to report nine measures via the Administrative methodology. These measures were CIS, CCS, COL, CDC, HPV, FPC, IMA, W15, and W34. For CDC, Kaiser was required to report the Eye Exam indicator using the Hybrid methodology.

AlohaCare's Performance

NCQA HEDIS Compliance Audit

HSAG's review team validated AlohaCare's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) AlohaCare was found to be *Fully Compliant* with all but one applicable IS assessment standards and was *Substantially Compliant* with IS 5.0 (Supplemental Data—Capture, Transfer, and Entry). With the exception of supplemental data use, this finding demonstrated that AlohaCare had the automated systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures.

AlohaCare elected to use three standard and two nonstandard supplemental data sources for its performance measure reporting. The auditors identified that the electronic medical record data from AlohaCare's three health centers did not include all the required data elements in their data files. Consequently, this supplemental data source was not approved for reporting. Nonetheless, since AlohaCare could still use medical record abstracted data to report its measures, the impact of not having this data source approved was mitigated.

Although AlohaCare was *Fully Compliant* with IS 4.0 (Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight), more than one sample was required for medical record review validation. Before the auditors passed the health plan on this validation, AlohaCare conducted a root cause analysis pertaining to the *Comprehensive Diabetes Care—Eye Exam*, *Colorectal Cancer Screening*, and *Postpartum Care* measures and developed a mechanism to prevent the abstraction errors in the future. AlohaCare removed cases that involved abstraction errors from the numerator category.

Based on AlohaCare's data systems and processes, the auditors made several recommendations:

- Regarding its enrollment data process, instead of waiting for new enrollment contact information to be received in the 834 file from the State, AlohaCare should consider utilizing the new member contact information once it is received from the member. This recommendation was also made by the auditor in 2014.
- Regarding its practitioner data process, AlohaCare should conduct an independent verification of the data entered. Currently, data entry and verification were performed by the same staff.

- Regarding its data transfer process, AlohaCare should create more robust processes to monitor the accuracy and completeness of the file transfer process so as to enhance its ability to compare records sent to its software vendor and those input into the software.

All non-ABD measures for which AlohaCare was required to report received the audit results of *Report*, although three measures had at least one indicator with a denominator too small to report a valid rate.

NON-ABD HEDIS PERFORMANCE MEASURE RESULTS

CHILDREN'S PREVENTIVE CARE

AlohaCare's Children's Preventive Care performance measure results are shown in Table 3-3. Of the 19 *Childhood Immunization Status* indicators, 15 indicators showed a rate increase and three showed a rate decrease. One indicator reported a significant improvement (*Influenza*: 8.03 percentage points) and one reported no change from last year's rate. Five measure rates in the Children's Preventive Care domain were at or above the national Medicaid 50th percentile but below the 75th percentile, six measures were at or above the 25th percentile but below the 50th percentile, and the remaining measures were below the 25th percentile.

Table 3-3—AlohaCare's HEDIS Results for Non-ABD Measures Under Children's Preventive Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	--	47.45%	--	★★
Childhood Immunization Status				
DTaP	64.23%	64.23%	0.00	★
IPV	79.81%	79.56%	-0.25	★
MMR	77.13%	79.56%	+2.43	★
HiB	80.29%	79.32%	-0.97	★
Hepatitis B	75.43%	80.54%	+5.11	★
VZV	76.16%	79.56%	+3.40	★
Pneumococcal Conjugate	63.26%	65.69%	+2.43	★
Hepatitis A	72.75%	71.53%	-1.22	★
Rotavirus	54.01%	55.23%	+1.22	★
Influenza	48.66%	56.69%	**+8.03**	★★★
Combination #2	59.85%	60.83%	+0.98	★
Combination #3	56.69%	58.39%	+1.70	★
Combination #4	53.77%	56.20%	+2.43	★
Combination #5	40.63%	42.58%	+1.95	★
Combination #6	40.88%	45.50%	+4.62	★★★
Combination #7	39.66%	41.36%	+1.70	★
Combination #8	40.15%	44.04%	+3.89	★★★
Combination #9	31.63%	32.60%	+0.97	★★
Combination #10	31.39%	31.87%	+0.48	★★

Table 3-3—AlohaCare's HEDIS Results for Non-ABD Measures Under Children's Preventive Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Immunization for Adolescents				
Meningococcal	--	57.42%	--	★
Tdap/Td	--	66.42%	--	★
Combined	--	55.23%	--	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation	--	61.07%	--	★★★
Counseling for Nutrition	--	54.01%	--	★★
Counseling for Physical Activity	--	52.07%	--	★★★
Well-Child Visits in the First 15 Months of Life				
0 Visits[1]	1.70%	1.70%	0.00	★★
6 or More Visits	64.48%	57.91%	-6.57	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	--	64.72%	--	★

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

WOMEN'S HEALTH

AlohaCare's Women's Health performance measure results are shown in Table 3-4. One measure in this domain showed significant improvement (*Breast Cancer Screening*: 25.24 percentage points). Two indicators for *Chlamydia Screening in Women* showed performance decline, and one indicator showed improvement, though none of these changes were statistically significant. Two measure rates were at or above the national Medicaid 25th percentile but below the 50th percentile, and the remaining measures were below the 25th percentile.

Table 3-4—AlohaCare's HEDIS Results for Non-ABD Measures Under Women's Health

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	28.28%	53.52%	**+25.24**	★★
Cervical Cancer Screening				
Cervical Cancer Screening	--	62.53%	--	★★
Chlamydia Screening in Women				
16–20 Years	44.03%	42.17%	-1.86	★
21–24 Years	46.93%	47.39%	+0.46	★
Total	45.61%	44.79%	-0.82	★
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	--	10.71%	--	★

CARE FOR CHRONIC CONDITIONS

AlohaCare's Care for Chronic Conditions performance measure results are shown in Table 3-5. Three rates in this domain reported a statistically significant improvement of more than 5 percentage points (*Comprehensive Diabetes Care—HbA1c Testing*, *Nephropathy*, and *Blood Pressure Control <140/90*). Two measure rates were at or above the national Medicaid 50th percentile but below the 75th percentile, two measures were at or above the 25th percentile but below the 50th percentile, and the remaining measures were below the 25th percentile.

Table 3-5—AlohaCare's HEDIS Results for Non-ABD Measures Under Care for Chronic Conditions

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	77.78%	84.52%	**+6.74**	★★★
HbA1c Poor Control (>9.0%)[1]	59.37%	55.74%	-3.63	★
HbA1c Control (<8.0%)	31.34%	35.34%	+4.00	★
HbA1c Control (<7.0%)	18.26%	21.70%	+3.44	★
Eye Exam	51.08%	55.74%	+4.66	★★★
Nephropathy	72.80%	79.05%	**+6.25**	★★
Blood Pressure Control (<140/90)	51.24%	60.29%	**+9.05**	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	43.31%	45.26%	+1.95	★

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

ACCESS TO CARE

AlohaCare's Access to Care performance measure results are shown in Table 3-6. Two measure rates were at or above the national Medicaid 25th percentile but below the 50th percentile, and nine measures were below the 25th percentile.

Table 3-6—AlohaCare's HEDIS Results for Non-ABD Measures Under Access to Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	--	70.48%	--	★
45–64 years	--	79.17%	--	★
65+ years	--	NA	--	--
Total	--	73.41%	--	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 months	--	95.80%	--	★
25 months–6 years	--	85.42%	--	★
7–11 years	--	87.95%	--	★★
12–19 years	--	84.18%	--	★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	--	33.24%	--	★
Engagement of AOD Treatment	--	7.84%	--	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	--	67.64%	--	★
Postpartum Care	--	51.82%	--	★

UTILIZATION

AlohaCare's Utilization performance measure results are shown in Table 3-7. One measure rate in this domain was at or above the national Medicaid 75th percentile but below the 90th percentile, one measure was at or above the 25th percentile but below the 50th percentile, and two measures were below the 25th percentile.

Table 3-7—AlohaCare's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Ambulatory Care			
ED Visits/1,000[1]	--	48.26	★★★★
Outpatient Visits/1,000	--	272.78	★
Enrollment by Product Line[2]			
0–19 years	--	0.54	--
20–44 years	--	0.31	--
45–64 years	--	0.14	--
65+ years	--	0.00	--
Frequency of Ongoing Prenatal Care			
<21 Percent[1]	--	15.09%	★★
81+ Percent	--	36.50%	★
Inpatient Utilization—General Hospital/Acute Care[3]			
Total Inpatient Discharges/1,000	--	6.44	--
Total Inpatient Days/1,000	--	28.24	--
Total Inpatient Average Length of Stay	--	4.38	--
Total Medicine Discharges/1,000	--	2.74	--
Total Medicine Days/1,000	--	11.41	--
Total Medicine Average Length of Stay	--	4.16	--
Total Surgery Discharges/1,000	--	1.33	--
Total Surgery Days/1,000	--	10.90	--
Total Surgery Average Length of Stay	--	8.19	--
Total Maternity Discharges/1,000	--	3.40	--
Total Maternity Days/1,000	--	8.51	--
Total Maternity Average Length of Stay	--	2.50	--
Mental Health Utilization[3]			
Mental Health Utilization—Total (Any Services)	--	8.29%	--
Mental Health Utilization—Total (Inpatient Services)	--	0.41%	--
Mental Health Utilization—Total (Intensive Outpatient Services)	--	0.08%	--
Mental Health Utilization—Total (Ambulatory/ED Visits)	--	8.12%	--

Table 3-7—AlohaCare's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Plan All-Cause Readmissions			
PCR Total[1,2,4]	--	11.99%	--

[1]*A lower rate indicates better performance for this measure. For performance level evaluation, if the measure had applicable benchmarks, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[3]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

[4]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Commercial weights for the non-ABD population.*

EFFECTIVENESS OF CARE

AlohaCare's Effectiveness of Care performance measure results are shown in Table 3-8. One measure rate in this domain was at or above the national Medicaid 75th percentile but below the 90th percentile, six measures were at or above the 50th percentile but below the 75th percentile, and 13 measures were below the 50th percentile.

Table 3-8—AlohaCare's HEDIS Results for Non-ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	--	17.95%	--	★
Adult BMI Assessment				
Adult BMI Assessment	--	83.94%	--	★★★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	--	86.91%	--	★★
Digoxin	--	NA	--	--
Diuretics	--	85.75%	--	★★
Total	--	86.12%	--	★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	--	45.45%	--	★★
Effective Continuation Phase Treatment	--	31.67%	--	★★
Colorectal Cancer Screening[1]				
Colorectal Cancer Screening	--	26.76%	--	--
Follow-Up After Hospitalization for Mental Illness				
7 Days	--	20.59%	--	★

Table 3-8—AlohaCare's HEDIS Results for Non-ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
30 Days	--	41.18%	--	★
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	--	40.38%	--	★★
Continuation Phase	--	NA	--	--
Medication Management for People With Asthma				
Medication Compliance 50%	--	54.42%	--	★★★
Medication Compliance 75%	--	30.45%	--	★★★
Persistence of Beta Blocker Treatment After a Heart Attack				
Persistence of Beta Blocker Treatment After a Heart Attack	--	88.00%	--	★★★
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	--	70.11%	--	★★★
Bronchodilator	--	83.91%	--	★★★
Use of Appropriate Medications for People With Asthma				
5–11 years	--	74.72%	--	★
12–18 years	--	71.54%	--	★
19–50 years	--	71.43%	--	★★
51–64 years	--	80.22%	--	★★★★
Total	--	73.45%	--	★

[1]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Conclusions and Recommendations

Compared to HEDIS 2014, five HEDIS 2015 rates demonstrated a statistically significant increase, and no measures demonstrated a statistically significant decrease. Of the 78 non-ABD rates compared to national HEDIS 2014 Medicaid percentiles, more than half of AlohaCare's measure results ranked below the 25th percentile, and only two ranked above the 75th percentile but below the 90th percentile.

For HEDIS 2015, none of the performance measure results showed significant decline from the prior year. However, HSAG noted that many performance measure rates ranked below the national Medicaid 25th percentiles. These measures spread across different categories. HSAG recommends that AlohaCare focus on these measures for improvement:

- Children's Preventive Care:
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health:
  - *Chlamydia Screening in Women*

  - *Human Papillomavirus Vaccine for Female Adolescents*
- Care for Chronic Conditions:
  - *Comprehensive Diabetes Care—HbA1c Control indicators*
  - *Controlling High Blood Pressure*
- Access to Care: All measures
- Utilization:
  - *Ambulatory Care—Outpatient Visits*
  - *Frequency of Ongoing Prenatal Care*
- Effectiveness of Care:
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
  - *Follow-Up After Hospitalization for Mental Illness*
  - *Use of Appropriate Medications for People With Asthma*

HSAG recognizes that AlohaCare rolled out an incentive project in late 2014 for its non-ABD population providers and a three-year incentive program targeting all providers in February 2015 to focus on several of these measures and to improve service delivery as well as data completeness.

HMSA's Performance

NCQA HEDIS Compliance Audit

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

HMSA elected to use two standard and two nonstandard supplemental data sources for its performance measure reporting. During the validation process of these supplemental data sources, HMSA indicated that one of the nonstandard data sources did not have supporting documentation for the auditors to conduct proof-of-service verification. This data source was therefore withdrawn from being included for reporting. All other supplemental data sources were validated and approved for measure reporting.

HMSA passed the medical record review validation on its first set of samples.

Based on HMSA's data systems and processes, the auditors made one recommendation:

- Regarding its enrollment data process, instead of waiting for new enrollment contact information to be received in the 834 file from the State, HMSA should consider utilizing the new member contact information once it is received from the member. This recommendation was also made by the auditor in 2014.

All non-ABD measures that HMSA was required to report received the audit results of *Report*, although one measure had at least one indicator with a denominator too small to report a valid rate.

NON-ABD HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE

HMSA's Children's Preventive Care performance measure results are shown in Table 3-9. Of the 19 *Childhood Immunization Status* indicators, 10 indicators showed a significant decrease. *Well-Child Visits in the First 15 Months of Life—Six or More Visits* reported a significant improvement (6.90 percentage points). One measure rate in this domain was at or above the 90th percentile, one measure rate was at or above the 75th percentile but below the 90th percentile, one measure rate was above the 50th percentile but below the 75th percentile, and the remaining measures were below the 50th percentile.

Table 3-9—HMSA's HEDIS Results for Non-ABD Measures Under Children's Preventive Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	--	47.69%	--	★★
Childhood Immunization Status				
DTaP	75.18%	70.07%	-5.11	★
IPV	86.86%	82.00%	-4.86	★
MMR	91.00%	90.51%	-0.49	★★
HiB	87.59%	87.59%	0.00	★
Hepatitis B	89.29%	68.86%	**-20.43**	★
VZV	89.54%	89.05%	-0.49	★★
Pneumococcal Conjugate	77.37%	72.02%	-5.35	★
Hepatitis A	64.48%	65.69%	+1.21	★
Rotavirus	58.88%	58.64%	-0.24	★
Influenza	48.66%	40.88%	**-7.78**	★★
Combination #2	71.78%	55.96%	**-15.82**	★
Combination #3	68.37%	52.55%	**-15.82**	★
Combination #4	55.72%	46.96%	**-8.76**	★
Combination #5	48.91%	42.09%	**-6.82**	★
Combination #6	42.82%	32.12%	**-10.70**	★
Combination #7	44.77%	39.66%	-5.11	★
Combination #8	38.93%	30.41%	**-8.52**	★
Combination #9	35.52%	28.22%	**-7.30**	★★
Combination #10	33.33%	27.01%	**-6.32**	★★
Immunization for Adolescents				
Meningococcal	--	48.91%	--	★
Tdap/Td	--	54.50%	--	★
Combined	--	45.99%	--	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation	--	63.26%	--	★★★
Counseling for Nutrition	--	38.93%	--	★

Table 3-9—HMSA's HEDIS Results for Non-ABD Measures Under Children's Preventive Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Counseling for Physical Activity	--	35.77%	--	★
Well-Child Visits in the First 15 Months of Life				
0 Visits[1]	1.15%	1.72%	+0.57	★★
6 or More Visits	70.40%	77.30%	**+6.90**	★★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	--	79.02%	--	★★★★

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

WOMEN'S HEALTH

HMSA's Women's Health performance measure results are shown in Table 3-10. Two indicators for *Chlamydia Screening in Women* showed statistically significant decrease (*21–24 Years* and *Total*). *Breast Cancer Screening* showed a rate increase, although this change was not statistically significant. Two measure rates were at or above the national Medicaid 75th percentile but below the 90th percentile, two measure rates were at or above the 50th percentile but below the 75th percentile, and two rates were at or above the 25th percentile but below the 50th percentile.

Table 3-10—HMSA's HEDIS Results for Non-ABD Measures Under Women's Health				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	64.69%	67.14%	+2.45	★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	--	66.39%	--	★★★
Chlamydia Screening in Women				
16–20 Years	61.51%	59.00%	-2.51	★★★★
21–24 Years	66.40%	63.30%	**-3.10**	★★
Total	64.02%	61.11%	**-2.91**	★★★
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	--	17.03%	--	★★

CARE FOR CHRONIC CONDITIONS

HMSA's Care for Chronic Conditions performance measure results are shown in Table 3-11. Among the *Comprehensive Diabetes Care* indicators, one measure rate showed significant improvement (*Blood Pressure Control <140/90* with an increase of 8.86 percentage points). Two measure rates were at or above the 50th percentile but below the 75th percentile. The remaining rates were below the 50th percentile.

Table 3-11—HMSA's HEDIS Results for Non-ABD Measures Under Care for Chronic Conditions

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	83.73%	81.75%	-1.98	★★
HbA1c Poor Control (>9.0%)[1]	49.73%	48.91%	-0.82	★★
HbA1c Control (<8.0%)	42.23%	41.24%	-0.99	★★
HbA1c Control (<7.0%)	27.90%	27.05%	-0.85	★
Eye Exam	57.40%	57.85%	+0.45	★★★
Nephropathy	79.34%	81.57%	+2.23	★★★
Blood Pressure Control (<140/90)	41.50%	50.36%	**+8.86**	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	45.99%	39.66%	-6.33	★

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

ACCESS TO CARE

HMSA's Access to Care performance measure results are shown in Table 3-12. Two measure rates were at or above the 75th percentile but below the 90th percentile, three rates were at or above the 50th percentile but below the 75th percentile, and six rates were below the 50th percentile.

Table 3-12—HMSA's HEDIS Results for Non-ABD Measures Under Access to Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	--	78.08%	--	★
45–64 years	--	85.79%	--	★
65+ years	--	NA	--	--
Total	--	80.70%	--	★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 months	--	97.55%	--	★★★

Table 3-12—HMSA's HEDIS Results for Non-ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
25 months–6 years	--	92.70%	--	★★★★
7–11 years	--	93.20%	--	★★★
12–19 years	--	91.47%	--	★★★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	--	37.30%	--	★★
Engagement of AOD Treatment	--	17.08%	--	★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	--	67.64%	--	★
Postpartum Care	--	46.96%	--	★

UTILIZATION

HMSA's Utilization performance measure results are shown in Table 3-13. One measure rate in this domain was at or above the national Medicaid 75th percentile but below the 90th percentile, one measure was at or above the 25th percentile but below the 50th percentile, and two measures were below the 25th percentile.

Table 3-13—HMSA's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Ambulatory Care			
ED Visits/1,000[1]	--	41.00	★★★★
Outpatient Visits/1,000	--	330.28	★★
Enrollment by Product Line[2]			
0–19 years	--	0.56	--
20–44 years	--	0.30	--
45–64 years	--	0.14	--
65+ years	--	0.00	--
Frequency of Ongoing Prenatal Care			
<21 Percent[1]	--	21.41%	★
81+ Percent	--	27.74%	★
Inpatient Utilization—General Hospital/Acute Care[3]			
Total Inpatient Discharges/1,000	--	5.34	--
Total Inpatient Days/1,000	--	21.36	--
Total Inpatient Average Length of Stay	--	4.00	--
Total Medicine Discharges/1,000	--	2.14	--
Total Medicine Days/1,000	--	8.97	--

Table 3-13—HMSA's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Total Medicine Average Length of Stay	--	4.18	--
Total Surgery Discharges/1,000	--	1.00	--
Total Surgery Days/1,000	--	6.80	--
Total Surgery Average Length of Stay	--	6.83	--
Total Maternity Discharges/1,000	--	3.23	--
Total Maternity Days/1,000	--	8.20	--
Total Maternity Average Length of Stay	--	2.54	--
Mental Health Utilization[3]			
Mental Health Utilization—Total (Any Services)	--	9.98%	--
Mental Health Utilization—Total (Inpatient Services)	--	0.42%	--
Mental Health Utilization—Total (Intensive Outpatient Services)	--	0.09%	--
Mental Health Utilization—Total (Ambulatory/ED Visits)	--	9.85%	--
Plan All-Cause Readmissions			
PCR Total[1,2,4]	--	11.27%	--

[1]*A lower rate indicates better performance for this measure. For performance level evaluation, if the measure had applicable benchmarks, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[3]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

[4]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Commercial weights for the non-ABD population.*

EFFECTIVENESS OF CARE

HMSA's Effectiveness of Care performance measure results are shown in Table 3-14. One measure rate in this domain was at or above the national Medicaid 75th percentile but below the 90th percentile and 15 measures were below the 50th percentile.

Table 3-14—HMSA's HEDIS Results for Non-ABD Measures Under Effectiveness of Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	--	32.83%	--	★
Adult BMI Assessment				
Adult BMI Assessment	--	69.21%	--	★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	--	89.13%	--	★★★
Digoxin	--	42.25%	--	★
Diuretics	--	87.32%	--	★★
Total	--	87.98%	--	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	--	46.97%	--	★★
Effective Continuation Phase Treatment	--	31.45%	--	★★
Colorectal Cancer Screening[1]				
Colorectal Cancer Screening	--	43.80%	--	--
Follow-Up After Hospitalization for Mental Illness				
7 Days	--	29.30%	--	★
30 Days	--	49.30%	--	★
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	--	34.17%	--	★★
Continuation Phase	--	35.29%	--	★
Medication Management for People With Asthma				
Medication Compliance 50%	--	56.54%	--	★★★
Medication Compliance 75%	--	31.56%	--	★★★
Persistence of Beta Blocker Treatment After a Heart Attack				
Persistence of Beta Blocker Treatment After a Heart Attack	--	73.08%	--	★
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	--	70.80%	--	★★★
Bronchodilator	--	88.32%	--	★★★★

Table 3-14—HMSA's HEDIS Results for Non-ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Use of Appropriate Medications for People With Asthma				
5–11 years	--	80.81%	--	★
12–18 years	--	76.24%	--	★
19–50 years	--	68.92%	--	★
51–64 years	--	76.65%	--	★★★
Total	--	74.73%	--	★

[1] *Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Conclusions and Recommendations

Compared to HEDIS 2014, two HEDIS 2015 rates reported a statistically significant increase and 12 measures reported a statistically significant decrease. Of the 80 non-ABD rates compared to national HEDIS 2014 Medicaid percentiles, almost 75 percent of HMSA's measure results ranked below the 50th percentile (i.e., 58 measures) and one measure ranked at or above the 90th percentile.

Although HMSA indicated that improvement efforts were put forth to improve the *Childhood Immunization Status* measure, several indicators from this measure showed significant decline from the year prior and ranked below the 25th percentile. HSAG also recognizes that HMSA conducted data analyses and education interventions to improve performance on the *Comprehensive Diabetes Care* measure. Nonetheless, the HEDIS 2015 rates remained fairly stable compared to HEDIS 2014. Many other performance measure rates fell below the national Medicaid 25th percentile. These measures spread across different categories. HSAG recommends that HMSA focus on these measures for improvement:

- Children's Preventive Care:
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition and Counseling for Physical Activity*
- Care for Chronic Conditions:
  - *Comprehensive Diabetes* Care—HbA1c *Control <7%* and *Blood Pressure Control <140/90 mm Hg*
  - *Controlling High Blood Pressure*
- Access to Care:
  - *Adults' Access to Preventive/Ambulatory Health Services*
  - *Prenatal and Postpartum Care*
- Utilization:
  - *Frequency of Ongoing Prenatal Care*
- Effectiveness of Care:

- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Adult BMI Assessment*
- *Annual Monitoring for Patients on Persistent Medications—Digoxin*
- *Follow-Up After Hospitalization for Mental Illness*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase*
- *Persistence of Beta-Blocker Treatment After a Heart Attack*
- *Use of Appropriate Medications for People With Asthma*

Kaiser's Performance

NCQA HEDIS Compliance Audit

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

Kaiser elected to use one standard and two nonstandard supplemental data sources for its performance measure reporting. During the validation process of these supplemental data sources, it was found that one of the nonstandard supplemental data sources did not apply to the MQD-required measures. All other supplemental data sources were validated and approved for measure reporting.

Kaiser did not use a software vendor to calculate its measures. Instead, the source code was developed in-house and subsequently approved by HSAG's review team. Due to its integrated electronic medical record and claims data systems, Kaiser received approval from the MQD to report nine measures via the administrative methodology. These measures were CIS, CCS, COL, CDC, HPV, FPC, IMA, W15, and W34. For CDC, Kaiser was required to report the *Eye Exam* indicator using the hybrid methodology.

The auditors did not make any recommendations regarding Kaiser's data systems and processes. Kaiser passed the medical record review validation on its first set of samples. All non-ABD measures Kaiser was required to report received the audit results of *Report*, although six measures had at least one indicator with a denominator too small to report a valid rate.

The auditor also did not make any recommendations specific to Kaiser's data systems or processes in HEDIS 2014 that required action.

NON-ABD HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE

Kaiser's Children's Preventive Care performance measure results are shown in Table 3-15. Of the 19 *Childhood Immunization Status* indicators, performance remained fairly stable between years. *Well-Child Visits in the First 15 Months of Life—Six or More Visits* reported a significant decrease (2.93 percentage points). Within this domain, 19 measure rates were at or above the 90th percentile, two were at or above the 75th percentile but below the 90th percentile, five were at or above the 50th percentile but below the 75th percentile, and two were below the 50th percentile.

Table 3-15—Kaiser's HEDIS Results for Non-ABD Measures Under Children's Preventive Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	--	45.08%	--	★★
Childhood Immunization Status				
DTaP	90.47%	89.91%	-0.56	★★★★★
IPV	94.12%	93.80%	-0.32	★★★
MMR	93.90%	93.20%	-0.70	★★★
HiB	94.12%	93.32%	-0.80	★★★
Hepatitis B	94.12%	94.29%	+0.17	★★★★
VZV	93.46%	92.71%	-0.75	★★★
Pneumococcal Conjugate	88.25%	89.19%	+0.94	★★★★★
Hepatitis A	93.57%	92.59%	-0.98	★★★★★
Rotavirus	89.91%	87.24%	-2.67	★★★★★
Influenza	84.15%	83.48%	-0.67	★★★★★
Combination #2	88.91%	88.58%	-0.33	★★★★★
Combination #3	86.36%	87.85%	+1.49	★★★★★
Combination #4	86.36%	87.61%	+1.25	★★★★★
Combination #5	82.48%	83.11%	+0.63	★★★★★
Combination #6	79.49%	80.32%	+0.83	★★★★★
Combination #7	82.48%	82.87%	+0.39	★★★★★
Combination #8	79.49%	80.19%	+0.70	★★★★★
Combination #9	76.05%	76.18%	+0.13	★★★★★
Combination #10	76.05%	76.06%	+0.01	★★★★★
Immunization for Adolescents				
Meningococcal	--	86.30%	--	★★★★
Tdap/Td	--	84.19%	--	★★
Combined	--	80.87%	--	★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation	--	93.92%	--	★★★★★
Counseling for Nutrition	--	98.05%	--	★★★★★

Table 3-15—Kaiser's HEDIS Results for Non-ABD Measures Under Children's Preventive Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Counseling for Physical Activity	--	98.05%	--	★★★★★
Well-Child Visits in the First 15 Months of Life				
0 Visits[1]	0.12%	0.28%	+0.16	★★★★
6 or More Visits	93.31%	90.38%	**-2.93**	★★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	--	87.08%	--	★★★★★

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

WOMEN'S HEALTH

Kaiser's Women's Health performance measure results are shown in Table 3-16. *Breast Cancer Screening* showed a slight decrease from last year's rate. *Chlamydia Screening in Women—21–24 Years* showed a significant decrease (1.05 percentage points); however, *Chlamydia Screening in Women—Total* showed a significant increase (2.29 percentage points). All measure rates in this domain were at or above the 90th percentile.

Table 3-16—Kaiser's HEDIS Results for Non-ABD Measures Under Women's Health				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	83.08%	81.41%	-1.67	★★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	--	81.00%	--	★★★★★
Chlamydia Screening in Women				
16–20 Years	66.26%	71.52%	+5.26	★★★★★
2–-24 Years	74.07%	73.02%	**-1.05**	★★★★★
Total	69.91%	72.20%	**+2.29**	★★★★★
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	--	35.06%	--	★★★★★

CARE FOR CHRONIC CONDITIONS

Kaiser's Care for Chronic Conditions performance measure results are shown in Table 3-17. *Comprehensive Diabetes Care—HbA1c Testing* demonstrated statistically significant improvement (2.65 percentage points). Five measure rates in this domain ranked at or above the 90th percentile,

two measure rates were at or above the 75th percentile but below the 90th percentile, and the remaining rate was below the 50th percentile.

Table 3-17—Kaiser's HEDIS Results for Non-ABD Measures Under Care for Chronic Conditions				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Comprehensive Diabetes Care[1]				
HbA1c Testing	94.36%	97.01%	**+2.65**	★★★★★
HbA1c Poor Control (>9.0%)[2]	34.39%	30.82%	-3.57	★★★★
HbA1c Control (<8.0%)	51.16%	55.14%	+3.98	★★★★
HbA1c Control (<7.0%)	31.72%	30.24%	-1.48	★★
Eye Exam	71.90%	74.82%	+2.92	★★★★★
Nephropathy	91.33%	93.76%	+2.43	★★★★★
Blood Pressure Control (<140/90)	83.76%	85.57%	+1.81	★★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	83.94%	80.78%	-3.16	★★★★★

[1]*This measure was reported using the hybrid methodology in 2014; however, the 2015 measure rate was calculated using administrative data only. As a result, trend analysis was not performed, and results should be interpreted with caution when comparing 2014 and 2015 rates.*

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

ACCESS TO CARE

Kaiser's Access to Care performance measure results are shown in Table 3-18. Two measure rates were at or above the 90th percentile, five rates were at or above the 75th percentile but below the 90th percentile, one rate was at or above the 50th percentile but below the 75th percentile, and three rates were below the 50th percentile.

Table 3-18—Kaiser's HEDIS Results for Non-ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	--	83.48%	--	★★★
45–64 years	--	87.59%	--	★★
65+ years	--	NA	--	--
Total	--	84.93%	--	★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 months	--	99.63%	--	★★★★★
25 Months–6 years	--	93.23%	--	★★★★

Table 3-18—Kaiser's HEDIS Results for Non-ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
7–11 years	--	93.74%	--	★★★★
12–19 years	--	92.29%	--	★★★★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	--	25.61%	--	★
Engagement of AOD Treatment	--	18.78%	--	★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	--	91.73%	--	★★★★
Postpartum Care	--	77.13%	--	★★★★★

UTILIZATION

Kaiser's Utilization performance measure results are shown in Table 3-19. Two measure rates in this domain were at or above the national Medicaid 90th percentile, one rate was at or above the 50th percentile but below the 75th percentile, and one rate was below the 25th percentile.

Table 3-19—Kaiser's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Ambulatory Care			
ED Visits/1,000[1]	--	23.89	★★★★★
Outpatient Visits/1,000	--	284.95	★
Enrollment by Product Line[2]			
0–19 years	--	0.64	--
20–44 years	--	0.24	--
45–64 years	--	0.12	--
65+ years	--	0.00	--
Frequency of Ongoing Prenatal Care			
<21 Percent[1]	--	0.23%	★★★★★
81+ Percent	--	67.43%	★★★
Inpatient Utilization—General Hospital/Acute Care[3]			
Total Inpatient Discharges/1,000	--	3.61	--
Total Inpatient Days/1,000	--	13.56	--
Total Inpatient Average Length of Stay	--	3.75	--
Total Medicine Discharges/1,000	--	1.46	--
Total Medicine Days/1,000	--	6.30	--
Total Medicine Average Length of Stay	--	4.32	--

Table 3-19—Kaiser's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Total Surgery Discharges/1,000	--	0.52	--
Total Surgery Days/1,000	--	3.34	--
Total Surgery Average Length of Stay	--	6.43	--
Total Maternity Discharges/1,000	--	2.57	--
Total Maternity Days/1,000	--	6.17	--
Total Maternity Average Length of Stay	--	2.40	--
Mental Health Utilization[3]			
Mental Health Utilization—Total (Any Services)	--	6.00%	--
Mental Health Utilization—Total (Inpatient Services)	--	0.33%	--
Mental Health Utilization—Total (Intensive Outpatient Services)	--	0.00%	--
Mental Health Utilization—Total (Ambulatory/ED Visits)	--	5.99%	--
Plan All-Cause Readmissions			
PCR Total[1,2,4]	--	15.59%	--

[1]*A lower rate indicates better performance for this measure. For performance level evaluation, if the measure had applicable benchmarks, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[3]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

[4]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Commercial weights for the non-ABD population.*

EFFECTIVENESS OF CARE

Kaiser's Effectiveness of Care performance measure results are shown in Table 3-20. Nine measure rates in this domain were at or above the national Medicaid 90th percentile, two measure rates were at or above the 75th percentile but below the 90th percentile, two measures were at or above the 50th percentile but below the 75th percentile, and three measures were below the 50th percentile.

Table 3-20—Kaiser's HEDIS Results for Non-ABD Measures Under Effectiveness of Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	--	NA	--	--
Adult BMI Assessment				
Adult BMI Assessment	--	97.21%	--	★★★★★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	--	91.04%	--	★★★★
Digoxin	--	NA	--	--
Diuretics	--	90.22%	--	★★★
Total	--	90.44%	--	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	--	47.64%	--	★★
Effective Continuation Phase Treatment	--	36.32%	--	★★★
Colorectal Cancer Screening[1]				
Colorectal Cancer Screening	--	70.66%	--	--
Follow-Up After Hospitalization for Mental Illness				
7 Days	--	65.82%	--	★★★★★
30 Days	--	75.95%	--	★★★★
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	--	55.32%	--	★★★★★
Continuation Phase	--	NA	--	--
Medication Management for People With Asthma				
Medication Compliance 50%	--	33.75%	--	★
Medication Compliance 75%	--	13.25%	--	★
Persistence of Beta Blocker Treatment After a Heart Attack				
Persistence of Beta Blocker Treatment After a Heart Attack	--	NA	--	--
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	--	NA	--	--
Bronchodilator	--	NA	--	--

Table 3-20—Kaiser's HEDIS Results for Non-ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Use of Appropriate Medications for People With Asthma				
5–11 years	--	98.04%	--	★★★★★
12–18 years	--	98.94%	--	★★★★★
19–50 years	--	96.72%	--	★★★★★
51–64 years	--	92.86%	--	★★★★★
Total	--	97.32%	--	★★★★★

[1]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Conclusions and Recommendations

Compared to HEDIS 2014, two HEDIS 2015 rates reported a statistically significant increase, and two measures reported a statistically significant decrease. Of the 74 non-ABD rates compared to national HEDIS 2014 Medicaid percentiles, more than half of Kaiser's measure results ranked at or above the 90th percentile, and only four ranked below the 25th percentile.

Similar to prior years, Kaiser continued to be the top-performing health plan across all measures. Only a few measures fell below the national 25th percentile. HSAG recommends that Kaiser focus on these measures for improvement:

- Access to Care:
  - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment*
- Utilization:
  - *Ambulatory Care—Outpatient Visits*
- Effectiveness of Care:
  - *Medication Management for People With Asthma*

'Ohana's Performance

NCQA HEDIS Compliance Audit

'Ohana was contracted with MQD to provide services for its non-ABD and ABD populations. Additionally, 'Ohana was contracted to provide behavioral health carve-out services for the CCS program. Since the data systems or processes used by 'Ohana to calculate and report the required measures for these populations/programs were not significantly different, its compliance with IS standards was assessed at the health plan level and not at the population/program level. Where applicable, the auditor made note of any data processes unique for capturing or managing data for specific populations in each standard.

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

'Ohana elected to use five standard and two nonstandard supplemental data sources for its performance measure reporting. All supplemental data sources were validated and approved for measure reporting. 'Ohana also passed the medical record review validation on its first set of samples.

Although 'Ohana was found to be *Fully Compliant* with all applicable IS assessment standards, the auditor made one recommendation regarding its encounter data systems and processes. For its CCS population, 'Ohana received behavioral health encounters from other Hawaii Medicaid health plans annually. This file receipt schedule did not allow sufficient coordination of services between physical and behavioral health services. In addition, 'Ohana CCS did not in return provide the behavioral health services data to the other physical health plans. The auditor recommended that 'Ohana work on obtaining these data monthly from the other health plans, or quarterly at a minimum. A two-way data exchange may further enhance data usability and reporting for all the health plans.

All non-ABD performance measures for which 'Ohana was required to report received the audit results of *Report*, although eight measures had at least one indicator with a denominator too small to report a valid rate.

All 36 ABD performance measures received the audit results of *Report*. Seven of them had at least one indicator with a denominator too small to report a valid rate.

All CCS performance measures also received the audit results of *Report*. Three of them had at least one indicator with a denominator too small to report a valid rate.

The auditor also did not make any recommendations specific to 'Ohana's data systems or processes in HEDIS 2014 that required action.

NON-ABD HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE

'Ohana's Children's Preventive Care non-ABD performance measure results are shown in Table 3-21. Of the 19 *Childhood Immunization Status* indicators, 15 indicators showed a rate increase, and four showed a rate decrease. One indicator for *Well-Child Visits in the First 15 Months of* Life showed significant performance improvement (*0 Visits*: -11.60 percentage points). One measure rate in this domain was at or above the national Medicaid 50th percentile but below the 75th percentile, six measures were at or above the 25th percentile but below the 50th percentile, and the remaining measures were below the 25th percentile.

Table 3-21—'Ohana's HEDIS Results for Non-ABD Measures Under Children's Preventive Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	--	32.12%	--	★
Childhood Immunization Status				
DTaP	47.37%	53.80%	+6.43	★
IPV	73.68%	62.66%	-11.02	★
MMR	73.68%	67.72%	-5.96	★
HiB	73.68%	65.19%	-8.49	★
Hepatitis B	63.16%	63.29%	+0.13	★
VZV	73.68%	65.82%	-7.86	★
Pneumococcal Conjugate	47.37%	51.27%	+3.90	★
Hepatitis A	63.16%	66.46%	+3.30	★
Rotavirus	31.58%	39.24%	+7.66	★
Influenza	42.11%	44.30%	+2.19	★★
Combination #2	36.84%	49.37%	+12.53	★
Combination #3	36.84%	44.30%	+7.46	★
Combination #4	31.58%	41.77%	+10.19	★
Combination #5	18.42%	33.54%	+15.12	★
Combination #6	26.32%	34.18%	+7.86	★★
Combination #7	15.79%	31.01%	+15.22	★
Combination #8	23.68%	33.54%	+9.86	★★
Combination #9	15.79%	25.32%	+9.53	★
Combination #10	15.79%	24.68%	+8.89	★
Immunization for Adolescents				
Meningococcal	--	48.68%	--	★
Tdap/Td	--	51.32%	--	★
Combined	--	43.42%	--	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation	--	67.40%	--	★★★
Counseling for Nutrition	--	50.61%	--	★★

Table 3-21—'Ohana's HEDIS Results for Non-ABD Measures Under Children's Preventive Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Counseling for Physical Activity	--	45.99%	--	★★
Well-Child Visits in the First 15 Months of Life				
0 Visits[1]	15.25%	3.65%	**-11.60**	★
6 or More Visits	47.46%	59.85%	+12.39	★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	--	62.29%	--	★

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

WOMEN'S HEALTH

'Ohana's Women's Health non-ABD performance measure results are shown in Table 3-22. Four measure rates in this domain were at or above the national Medicaid 25th percentile but below the 50th percentile, and the remaining measures were below the 25th percentile. However, two *Chlamydia Screening in Women* indicators showed significant improvement.

Table 3-22—'Ohana's HEDIS Results for Non-ABD Measures Under Women's Health				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	NA	51.96%	--	★★
Cervical Cancer Screening				
Cervical Cancer Screening	--	47.20%	--	★
Chlamydia Screening in Women				
16–20 Years	48.24%	46.46%	-1.78	★★
21–24 Years	51.54%	56.64%	**+5.10**	★★
Total	50.23%	53.26%	**+3.03**	★★
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	--	13.16%	--	★

CARE FOR CHRONIC CONDITIONS

'Ohana's Care for Chronic Conditions non-ABD performance measure results are shown in Table 3-23. Among the *Comprehensive Diabetes Care* indicators, five indicators showed performance improvement and two indicators showed a performance decline, although these changes were not statistically significant. Two measure rates in this domain were at or above the national Medicaid

50th percentile but below the 75th percentile, five measures were at or above the 25th percentile but below the 50th percentile, and the remaining measure was below the 25th percentile.

Table 3-23—'Ohana's HEDIS Results for Non-ABD Measures Under Care for Chronic Conditions				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	83.58%	83.70%	+0.12	★★
HbA1c Poor Control (>9.0%)[1]	56.72%	52.31%	-4.41	★★
HbA1c Control (<8.0%)	34.70%	39.90%	+5.20	★★
HbA1c Control (<7.0%)	25.57%	21.17%	-4.40	★
Eye Exam	50.75%	51.09%	+0.34	★★
Nephropathy	79.85%	81.02%	+1.17	★★★
Blood Pressure Control (<140/90)	63.06%	63.02%	-0.04	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	50.76%	52.80%	+2.04	★★

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

ACCESS TO CARE

'Ohana's Access to Care non-ABD performance measure results are shown in Table 3-24. One measure rate in this domain was at or above the national Medicaid 75th percentile but below the 90th percentile, one measure was at or above the 50th percentile but below the 75th percentile, one measure was at or above the 25th percentile but below the 50th percentile, and eight measures were below the 25th percentile.

Table 3-24—'Ohana's HEDIS Results for Non-ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	--	61.84%	--	★
45–64 years	--	76.62%	--	★
65+ years	--	NA	--	--
Total	--	67.59%	--	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 months	--	92.73%	--	★
25 months–6 years	--	80.86%	--	★
7–11 years	--	85.65%	--	★
12–19 years	--	77.45%	--	★

Table 3-24—'Ohana's HEDIS Results for Non-ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	--	38.07%	--	★★★
Engagement of AOD Treatment	--	15.40%	--	★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	--	75.88%	--	★
Postpartum Care	--	58.81%	--	★★

UTILIZATION

'Ohana's Utilization non-ABD performance measure results are shown in Table 3-25. One measure rate in this domain was at or above the national Medicaid 50th percentile but below the 75th percentile, two measures were at or above the 25th percentile but below the 50th percentile, and one measure was below the 25th percentile.

Table 3-25—'Ohana's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Ambulatory Care			
ED Visits/1,000[1]	--	57.25	★★★
Outpatient Visits/1,000	--	302.29	★
Enrollment by Product Line[2]			
0–19 years	--	0.29	--
20–44 years	--	0.46	--
45–64 years	--	0.25	--
65+ years	--	0.00	--
Frequency of Ongoing Prenatal Care			
<21 Percent[1]	--	13.82%	★★
81+ Percent	--	48.51%	★★
Inpatient Utilization—General Hospital/Acute Care[3]			
Total Inpatient Discharges/1,000	--	9.76	--
Total Inpatient Days/1,000	--	49.38	--
Total Inpatient Average Length of Stay	--	5.06	--
Total Medicine Discharges/1,000	--	4.89	--
Total Medicine Days/1,000	--	19.17	--
Total Medicine Average Length of Stay	--	3.92	--
Total Surgery Discharges/1,000	--	2.63	--

Table 3-25—'Ohana's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Total Surgery Days/1,000	--	24.87	--
Total Surgery Average Length of Stay	--	9.44	--
Total Maternity Discharges/1,000	--	2.72	--
Total Maternity Days/1,000	--	6.48	--
Total Maternity Average Length of Stay	--	2.39	--
Mental Health Utilization[3]			
Mental Health Utilization—Total (Any Services)	--	10.50%	--
Mental Health Utilization—Total (Inpatient Services)	--	0.82%	--
Mental Health Utilization—Total (Intensive Outpatient Services)	--	0.04%	--
Mental Health Utilization—Total (Ambulatory/ED Visits)	--	10.18%	--
Plan All-Cause Readmissions			
PCR Total[1,2,4]	--	16.01%	--

[1]*A lower rate indicates better performance for this measure. For performance level evaluation, if the measure had applicable benchmarks, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[3]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

[4]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Commercial weights for the non-ABD population.*

EFFECTIVENESS OF CARE

'Ohana's Effectiveness of Care non-ABD performance measure results are shown in Table 3-26. One measure rate in this domain was at or above the national Medicaid 50th percentile but below the 75th percentile, five measures were at or above the 25th percentile but below the 50th percentile, and six measures were below the 25th percentile.

Table 3-26—'Ohana's HEDIS Results for Non-ABD Measures Under Effectiveness of Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	--	43.24%	--	★
Adult BMI Assessment				
Adult BMI Assessment	--	81.02%	--	★★★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	--	86.67%	--	★★
Digoxin	--	NA	--	--
Diuretics	--	84.62%	--	★
Total	--	84.95%	--	★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	--	48.28%	--	★★
Effective Continuation Phase Treatment	--	33.91%	--	★★
Colorectal Cancer Screening[1]				
Colorectal Cancer Screening	--	24.57%	--	--
Follow-Up After Hospitalization for Mental Illness				
7 Days	--	32.73%	--	★★
30 Days	--	47.27%	--	★
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	--	NA	--	--
Continuation Phase	--	NA	--	--
Medication Management for People With Asthma				
Medication Compliance 50%	--	40.00%	--	★
Medication Compliance 75%	--	16.67%	--	★
Persistence of Beta Blocker Treatment After a Heart Attack				
Persistence of Beta Blocker Treatment After a Heart Attack	--	NA	--	--
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	--	NA	--	--
Bronchodilator	--	NA	--	--

Table 3-26—'Ohana's HEDIS Results for Non-ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Use of Appropriate Medications for People With Asthma				
5–11 years	--	NA	--	--
12–18 years	--	NA	--	--
19–50 years	--	NA	--	--
51–64 years	--	NA	--	--
Total	--	65.22%	--	★

[1]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Conclusions and Recommendations

Compared to HEDIS 2014, three 'Ohana HEDIS 2015 rates demonstrated statistically significant improvement. Of the 70 non-ABD rates compared to national HEDIS 2014 Medicaid percentiles, more than half of 'Ohana's measure results ranked below the 25th percentile, and only one ranked above the 75th percentile but below the 90th percentile.

'Ohana did not have any non-ABD performance measures showing significant decline from HEDIS 2014. HSAG recognizes that 'Ohana initiated or implemented many strategies in 2014 to improve its performance. However, several HEDIS 2015 rates fell below the national Medicaid 25th percentile. These measures spread across different categories. HSAG recommends that 'Ohana focus on these measures for improvement:

- Children's Preventive Care:
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health:
  - *Cervical Cancer Screening*
  - *Human Papillomavirus Vaccine for Female Adolescents*
- Care for Chronic Conditions:
  - *Comprehensive Diabetes Care—HbA1c Control <7%*
- Access to Care:
  - *Adults' Access to Preventive/Ambulatory Health Services*
  - *Children and Adolescents' Access to Primary Care Practitioners*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- Utilization:
  - *Ambulatory Care—Outpatient Visits*
- Effectiveness of Care:

- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Annual Monitoring for Patients on Persistent Medications—Diuretics*
- *Follow-Up After Hospitalization for Mental Illness—30 Days*
- *Medication Management for People With Asthma*
- *Use of Appropriate Medications for People With Asthma*

ABD HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE

'Ohana's Children's Preventive Care ABD performance measure results are shown in Table 3-27. Four measure rates in this domain were at or above the national Medicaid 75th percentile but below the 90th percentile, one measure was at or above the 50th percentile but below the 75th percentile, seven measures were at or above the 25th percentile but below the 50th percentile, and 15 measures were below the 25th percentile.

Table 3-27—'Ohana's HEDIS Results for ABD Measures Under Children's Preventive Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	--	45.74%	--	★★
Childhood Immunization Status				
DTaP	--	79.49%	--	★★
IPV	--	82.05%	--	★
MMR	--	87.18%	--	★
HiB	--	84.62%	--	★
Hepatitis B	--	79.49%	--	★
VZV	--	84.62%	--	★
Pneumococcal Conjugate	--	79.49%	--	★★
Hepatitis A	--	76.92%	--	★★
Rotavirus	--	43.59%	--	★
Influenza	--	64.10%	--	★★★★
Combination #2	--	69.23%	--	★
Combination #3	--	66.67%	--	★
Combination #4	--	61.54%	--	★★
Combination #5	--	35.90%	--	★
Combination #6	--	51.28%	--	★★★★
Combination #7	--	33.33%	--	★
Combination #8	--	51.28%	--	★★★★
Combination #9	--	25.64%	--	★
Combination #10	--	25.64%	--	★
Immunization for Adolescents				
Meningococcal	--	59.04%	--	★
Tdap/Td	--	65.06%	--	★
Combined	--	56.63%	--	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation	--	74.70%	--	★★★★
Counseling for Nutrition	--	56.93%	--	★★
Counseling for Physical Activity	--	50.61%	--	★★

Table 3-27—'Ohana's HEDIS Results for ABD Measures Under Children's Preventive Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Well-Child Visits in the First 15 Months of Life				
0 Visits[1]	--	NA	--	--
6 or More Visits	--	NA	--	--
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	--	72.07%	--	★★★

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

WOMEN'S HEALTH

'Ohana's Women's Health ABD performance measure results are shown in Table 3-28. Two measure rates were at or above the national Medicaid 25th percentile but below the 50th percentile, and three measure rates were below the 25th percentile.

Table 3-28—'Ohana's HEDIS Results for ABD Measures Under Women's Health				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	--	56.41%	--	★★
Cervical Cancer Screening				
Cervical Cancer Screening	--	58.78%	--	★★
Chlamydia Screening in Women				
16–20 Years	--	33.33%	--	★
21–24 Years	--	38.71%	--	★
Total	--	36.13%	--	★
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	--	NA	--	--

CARE FOR CHRONIC CONDITIONS

'Ohana's Care for Chronic Conditions ABD performance measure results are shown in Table 3-29. Among the *Comprehensive Diabetes Care* indicators, five indicators showed performance improvement and two indicators showed a performance decline, although these changes were not statistically significant. One measure rate in this domain was above the national Medicaid 90th percentile, one measure rate was at or above the 75th percentile but below the 90th percentile, and the remaining six measure rates were at or above the 50th percentile but below the 75th percentile.

Table 3-29—'Ohana's HEDIS Results for ABD Measures Under Care for Chronic Conditions				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	88.11%	87.93%	-0.18	★★★★
HbA1c Poor Control (>9.0%)[1]	39.16%	37.07%	-2.09	★★★
HbA1c Control (<8.0%)	52.05%	52.66%	+0.61	★★★
HbA1c Control (<7.0%)	32.93%	37.71%	+4.78	★★★
Eye Exam	63.54%	60.58%	-2.96	★★★
Nephropathy	86.51%	88.87%	+2.36	★★★★★
Blood Pressure Control (<140/90)	59.74%	62.77%	+3.03	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	60.50%	61.01%	+0.51	★★★

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

ACCESS TO CARE

'Ohana's Access to Care ABD performance measure results are shown in Table 3-30. Four indicators in this domain demonstrated a rate decrease, and three of those reported significant performance decline (*Adults' Access to Preventive/Ambulatory Health Services—20–44 years, 65+ years, and Total).* One measure rate was above the national Medicaid 90th percentile, two measure rates were at or above the 75th percentile but below the 90th percentile, two measure rates were at or above the 50th percentile but below the 75th percentile, five measure rates were at or above the 25th percentile but below the 50th percentile, and one measure was below the 25th percentile.

Table 3-30—'Ohana's HEDIS Results for ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	86.05%	83.68%	**-2.37**	★★★
45–64 years	92.15%	91.22%	-0.93	★★★★
65+ years	95.06%	91.65%	**-3.41**	★★★★
Total	91.87%	89.84%	**-2.03**	★★★★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 months	--	NA	--	--
25 months–6 years	--	90.08%	--	★★★
7–11 years	--	89.53%	--	★★
12–19 years	--	86.82%	--	★★

Table 3-30—'Ohana's HEDIS Results for ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	--	33.22%	--	★
Engagement of AOD Treatment	--	6.08%	--	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	--	80.65%	--	★★
Postpartum Care	--	58.06%	--	★★

UTILIZATION

'Ohana's Utilization ABD performance measure results are shown in Table 3-31. *Ambulatory Care—ED Visits/1,000* reported performance improvement and *Ambulatory Care—Outpatient Visits/1,000* reported performance decrease. Of the 12 *Inpatient Utilization—General Hospital/Acute Care* measure indicators, five rates increased and seven rates decreased. However, significance testing was not performed. (Statistical significance testing was only performed on measures where rates are presented as percentages.) One measure rate in this domain was above the national Medicaid 90th percentile, one measure was at or above the 50th percentile but below the 75th percentile, and two measures were below the 25th percentile.

Table 3-31—'Ohana's HEDIS Results for ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Ambulatory Care			
ED Visits/1,000[1]	76.11	75.15	★
Outpatient Visits/1,000	748.03	716.22	★★★★★
Enrollment by Product Line[2]			
0–19 years	--	0.11	--
20–44 years	--	0.18	--
45–64 years	--	0.35	--
65+ years	--	0.36	--
Frequency of Ongoing Prenatal Care			
<21 Percent[1]	--	6.45%	★★★
81+ Percent	--	32.26%	★
Inpatient Utilization—General Hospital/Acute Care[3]			
Total Inpatient Discharges/1,000	23.32	24.13	--
Total Inpatient Days/1,000	183.91	185.84	--
Total Inpatient Average Length of Stay	7.89	7.70	--
Total Medicine Discharges/1,000	16.04	16.70	--

Table 3-31—'Ohana's HEDIS Results for ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Total Medicine Days/1,000	90.71	93.15	--
Total Medicine Average Length of Stay	5.66	5.58	--
Total Surgery Discharges/1,000	7.00	7.22	--
Total Surgery Days/1,000	92.29	92.05	--
Total Surgery Average Length of Stay	13.18	12.75	--
Total Maternity Discharges/1,000	0.43	0.34	--
Total Maternity Days/1,000	1.41	1.08	--
Total Maternity Average Length of Stay	3.24	3.13	--
Mental Health Utilization[3]			
Mental Health Utilization—Total (Any Services)	--	20.99%	--
Mental Health Utilization—Total (Inpatient Services)	--	1.88%	--
Mental Health Utilization—Total (Intensive Outpatient Services)	--	0.06%	--
Mental Health Utilization—Total (Ambulatory/ED Visits)	--	20.16%	--
Plan All-Cause Readmissions			
PCR Total[1,2,4]	16.20%	19.09%	--

[1]*A lower rate indicates better performance for this measure. For performance level evaluation, if the measure had applicable benchmarks, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[3]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

[4]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Commercial weights for the non-ABD population.*

EFFECTIVENESS OF CARE

'Ohana's Effectiveness of Care ABD performance measure results are shown in Table 3-32. Five measure rates in this domain were above the national Medicaid 90th percentile, three measures were at or above the 75th percentile but below the 90th percentile, five measures were at or above the 50th percentile but below the 75th percentile, three measures were at or above the 25th percentile but below the 50th percentile, and three measures were below the 25th percentile.

Table 3-32—'Ohana's HEDIS Results for ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	--	75.56%	--	★★★★★
Adult BMI Assessment				
Adult BMI Assessment	--	81.49%	--	★★★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	--	91.93%	--	★★★★
Digoxin	--	49.59%	--	★
Diuretics	--	92.72%	--	★★★★★
Total	--	91.17%	--	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	--	54.32%	--	★★★
Effective Continuation Phase Treatment	--	41.35%	--	★★★★
Care for Older Adults[1]				
Advance Care Planning	--	23.60%	--	--
Medication Review	--	71.78%	--	--
Functional Status Assessment	--	63.75%	--	--
Pain Assessment	--	81.75%	--	--
Colorectal Cancer Screening[1]				
Colorectal Cancer Screening	--	37.23%	--	--
Follow-Up After Hospitalization for Mental Illness				
7 Days	--	32.11%	--	★★
30 Days	--	51.58%	--	★★
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	--	NA	--	--
Continuation Phase	--	NA	--	--
Medication Management for People With Asthma				
Medication Compliance 50%	--	70.83%	--	★★★★★
Medication Compliance 75%	--	45.83%	--	★★★★★
Medication Reconciliation Post-Discharge[1]				
Medication Reconciliation Post-Discharge	--	32.36%	--	--
Persistence of Beta Blocker Treatment After a Heart Attack				
Persistence of Beta Blocker Treatment After a Heart Attack	--	92.00%	--	★★★★
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	--	72.37%	--	★★★

Table 3-32—'Ohana's HEDIS Results for ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Bronchodilator	--	85.99%	--	★★★
Use of Appropriate Medications for People With Asthma				
5–11 years	--	NA	--	--
12–18 years	--	NA	--	--
19–50 years	--	71.00%	--	★★
51–64 years	--	74.56%	--	★★★
Total	--	74.71%	--	★
Use of Spirometry Testing in the Assessment and Diagnosis of COPD				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	--	21.05%	--	★

[1] *Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Conclusions and Recommendations

Compared to HEDIS 2014, three of 'Ohana's HEDIS 2015 measure rates reported a statistically significant decrease. Of the 74 ABD rates compared to national HEDIS 2014 Medicaid percentiles, 24 of 'Ohana's measure results ranked below the 25th percentile, and eight ranked above the 90th percentile. 'Ohana should continue to ensure that claims and encounter data are complete and accurate and increase the use of supplemental data sources for reporting all ABD measures.

For HEDIS 2015, one ABD measure result (*Adults' Access to Preventive/Ambulatory Health Services*) showed a significant decline from the prior year. Additionally, many rates fell below the national 25th percentile. Some of them were also measures noted for improvement for the non-ABD population. HSAG recommends that 'Ohana focus on the following measures across different categories for improvement and develop integrative strategies for its various populations:

- Children's Preventive Care:
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
- Women's Health:
  - *Chlamydia Screening in Women*
- Access to Care:
  - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment*
- Utilization:
  - *Ambulatory Care—Emergency Visits*
  - *Frequency of Ongoing Prenatal Care*
- Effectiveness of Care:
  - *Annual Monitoring for Patients on Persistent Medications—Digoxin*

- *Use of Appropriate Medications for People With Asthma—Total*
- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*

CCS HEDIS AND NON-HEDIS PERFORMANCE MEASURES RESULTS

ACCESS TO CARE

'Ohana CCS' Access to Care performance measure results are shown in Table 3-33. One of the rates in this domain showed an increase, and one of the rates showed a decrease. Both measure rates in this domain were at or above the national Medicaid 50th percentile but below the 75th percentile.

Table 3-33—'Ohana's HEDIS Results for CCS Measures Under Access to Care

	HEDIS 2014 Rate[1]	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment (Ages 18 and Above)	38.66%	40.76%	+2.10	★★★
Engagement of AOD Treatment (Ages 18 and Above)	13.45%	12.21%	-1.24	★★★

[1]*Less than one calendar year of data were reported for the measure in 2014. As a result, trend analysis was not performed, and results should be interpreted with caution when comparing 2014 and 2015 rates.*

UTILIZATION

'Ohana CCS' Utilization performance measure results are shown in Table 3-34. All indicators included in the *Mental Health Utilization* measure results increased and performance on the *Plan All-Cause Readmissions* measure results declined, although significance testing was not performed.

Table 3-34—'Ohana's HEDIS Results for CCS Measures Under Utilization

	HEDIS 2014 Rate[1]	HEDIS 2015 Rate	2015 Performance Level
Enrollment by Product Line[2]			
0–19 years	--	0.00	--
20–44 years	--	0.33	--
45–64 years	--	0.58	--
65+ years	--	0.09	--
Mental Health Utilization[3]			
Mental Health Utilization—Total (Any Services)	83.48%	85.12%	--
Mental Health Utilization—Total (Inpatient Services)	7.08%	11.35%	--
Mental Health Utilization—Total (Intensive Outpatient Services)	0.90%	1.53%	--
Mental Health Utilization—Total (Ambulatory/ED Visits)	81.98%	83.83%	--

Table 3-34—'Ohana's HEDIS Results for CCS Measures Under Utilization			
	HEDIS 2014 Rate[1]	HEDIS 2015 Rate	2015 Performance Level
Plan All-Cause Readmissions			
PCR Total[2,4,5]	16.41%	24.68%	--

[1]*Less than one calendar year of data were reported for the measure in 2014. As a result, trend analysis was not performed, and results should be interpreted with caution when comparing 2014 and 2015 rates.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[3]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

[4]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Medicare weights for the CCS population.*

[5]*A lower rate indicates better performance for this measure.*

EFFECTIVENESS OF CARE

'Ohana CCS' Effectiveness of Care performance measure results are shown in Table 3-35. Three of the rates showed a decrease, and one rate showed an increase, although significance testing was not performed. Results for the *Follow-Up After Hospitalization for Mental Illness—7 Days* indicator were at or above the national Medicaid 25th percentile but below the 50th percentile, and two measures fell below the 25th percentile.

Table 3-35—'Ohana's HEDIS Results for CCS Measures Under Effectiveness of Care				
	HEDIS 2014 Rate[1]	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NA	--	--
Behavioral Health Assessment[2]				
BHA Completion—Within 30 Days of Enrollment	NA	26.51%	--	--
BHA Completion—Within 31–60 Days of Enrollment	NA	9.71%	--	--
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	NA	--	--
Diabetes Monitoring for People with Diabetes and Schizophrenia				
Diabetes Monitoring for People with Diabetes and Schizophrenia	66.92%	57.00%	-9.92	★

Table 3-35—'Ohana's HEDIS Results for CCS Measures Under Effectiveness of Care				
	HEDIS 2014 Rate[1]	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Diabetes Screening for People With Schizophrenia or Bipolar Disorder				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	NA	NA	--	--
Follow-Up After Hospitalization for Mental Illness				
7 Days	35.56%	34.39%	-1.17	★★
30 Days	62.22%	50.19%	-12.03	★
Follow-Up with Assigned PCP Following Hospitalization for Mental Illness[2]				
30-Day Follow-Up	9.49%	14.20%	+4.71	--

[1]*Less than one calendar year of data were reported for the measure in 2014. As a result, trend analysis was not performed, and results should be interpreted with caution when comparing 2014 and 2015 rates.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Conclusions and Recommendations

Of the five CCS rates compared to national HEDIS 2014 Medicaid percentiles, two measures ranked above the 50th percentile but below the 75 percentile, one measure ranked above the 25th percentile but below the 50th percentile, and two measures fell below the 25th percentile.

For HEDIS 2015, none of the CCS measures had a significant decline from the prior year. However, HSAG noted a few measures with rates below the national 25th percentile. HSAG recommends that 'Ohana continue to work with other health plans on the following Effectiveness of Care measures to ensure data completeness as well as explore improvement opportunities:

- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Follow-Up After Hospitalization for Mental Illness—30 Days*

UnitedHealthcare Community Plan's Performance

NCQA HEDIS Compliance Audit

UHC CP was contracted with MQD to provide services for its non-ABD and ABD populations. Since the data systems or processes used by UHC CP to calculate and report the required measures for these populations were not distinctively different, HSAG assessed its compliance with IS standards at the health plan level and not at the population level. Where applicable, the auditor made note of any data processes unique for capturing or managing data for specific populations in each standard.

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

UHC CP elected to use four standard and three nonstandard supplemental data sources for its performance measure reporting. All supplemental data sources were validated and approved for measure reporting. UHC CP also passed the medical record review validation on its first set of samples. The auditor did not make any recommendations for UHC CP's data systems and process.

All non-ABD performance measures that UHC CP was required to report received the audit results of *Report*, although seven measures had at least one indicator with a denominator too small to report a valid rate.

All 36 ABD performance measures received the audit results of *Report*. Nine of them had at least one indicator with a denominator too small to report a valid rate.

The auditor also did not make any recommendations specific to UHC CP's data systems and processes in HEDIS 2014 that required action.

NON-ABD HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE

UHC CP's Children's Preventive Care non-ABD performance measure results are shown in Table 3-36. For *Childhood Immunization Status*, UHC CP did not have applicable HEDIS 2014 rates for comparison, so percentage point change was not shown. Within this domain, one measure rate was at or above the 50th percentile but below the 75th percentile, seven were at or above the 25th percentile but below the 50th percentile, and the remaining rates were below the 25th percentile.

Table 3-36—UHC CP's HEDIS Results for Non-ABD Measures Under Children's Preventive Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	--	27.98%	--	★
Childhood Immunization Status				
DTaP	NA	65.71%	--	★
IPV	NA	74.29%	--	★
MMR	NA	75.00%	--	★
HiB	NA	77.14%	--	★
Hepatitis B	NA	72.14%	--	★
VZV	NA	77.14%	--	★
Pneumococcal Conjugate	NA	60.71%	--	★
Hepatitis A	NA	72.14%	--	★
Rotavirus	NA	52.14%	--	★
Influenza	NA	49.29%	--	★★
Combination #2	NA	55.71%	--	★
Combination #3	NA	52.86%	--	★
Combination #4	NA	50.71%	--	★
Combination #5	NA	39.29%	--	★
Combination #6	NA	38.57%	--	★★
Combination #7	NA	37.86%	--	★
Combination #8	NA	37.14%	--	★★
Combination #9	NA	31.43%	--	★★
Combination #10	NA	30.00%	--	★★
Immunization for Adolescents				
Meningococcal	--	25.30%	--	★
Tdap/Td	--	30.12%	--	★
Combined	--	22.89%	--	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation	--	64.72%	--	★★★
Counseling for Nutrition	--	56.20%	--	★★
Counseling for Physical Activity	--	43.31%	--	★★

Table 3-36—UHC CP's HEDIS Results for Non-ABD Measures Under Children's Preventive Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Well-Child Visits in the First 15 Months of Life				
0 Visits[1]	9.84%	5.00%	-4.84	★
6 or More Visits	55.74%	54.55%	-1.19	★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	--	57.66%	--	★

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

WOMEN'S HEALTH

UHC CP's Women's Health non-ABD performance measure results are shown in Table 3-37. UHC CP had too few members (<30) to be included in calculating the *Breast Cancer Screening* measure, resulting in an NA designation for HEDIS 2014. *Chlamydia Screening in Women—21–24 Years* and *Total* reported a statistically significant decrease. Two measure rates in this domain were at or above the national Medicaid 25th percentile but below the 50th percentile, and four rates were below the 25th percentile.

Table 3-37—UHC CP's HEDIS Results for Non-ABD Measures Under Women's Health				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	NA	47.14%	--	★
Cervical Cancer Screening				
Cervical Cancer Screening	--	42.09%	--	★
Chlamydia Screening in Women				
16–20 Years	38.33%	48.48%	+10.15	★★
21–24 Years	59.15%	51.18%	**-7.97**	★
Total	52.97%	50.42%	**-2.55**	★★
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	--	4.65%	--	★

CARE FOR CHRONIC CONDITIONS

UHC CP's Care for Chronic Conditions non-ABD performance measure results are shown in Table 3-38. Among the *Comprehensive Diabetes Care* indicators, five indicators showed performance improvement and two indicators showed a performance decline. Results for *Controlling High Blood Pressure* reflected performance improvement. These changes were not statistically significant. Two measure rates were at or above the 50th percentile but below the 75th percentile. The remaining rates were below the 50th percentile.

Table 3-38—UHC CP's HEDIS Results for Non-ABD Measures Under Care for Chronic Conditions

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	79.81%	81.00%	+1.19	★★
HbA1c Poor Control (>9.0%)[1]	62.02%	59.05%	-2.97	★
HbA1c Control (<8.0%)	32.69%	33.26%	+0.57	★
HbA1c Control (<7.0%)	20.37%	19.88%	-0.49	★
Eye Exam	62.98%	62.90%	-0.08	★★★
Nephropathy	78.85%	81.45%	+2.60	★★★
Blood Pressure Control (<140/90)	49.52%	50.68%	+1.16	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	43.10%	50.12%	+7.02	★★

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

ACCESS TO CARE

UHC CP's Access to Care non-ABD performance measure results are shown in Table 3-39. One measure rate was at or above the 25th percentile but below the 50th percentile, and 10 rates were below the 25th percentile.

Table 3-39—UHC CP's HEDIS Results for Non-ABD Measures Under Access to Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	--	61.64%	--	★
45–64 years	--	75.93%	--	★
65+ years	--	NA	--	--
Total	--	67.05%	--	★

Table 3-39—UHC CP's HEDIS Results for Non-ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Children and Adolescents' Access to Primary Care Practitioners				
12–24 months	--	90.84%	--	★
25 months–6 years	--	77.33%	--	★
7–11 years	--	86.05%	--	★
12–19 years	--	78.71%	--	★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	--	31.97%	--	★
Engagement of AOD Treatment	--	7.86%	--	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	--	62.61%	--	★
Postpartum Care	--	49.58%	--	★

UTILIZATION

UHC CP's Utilization non-ABD performance measure results are shown in Table 3-40. One measure rate in this domain was at or above the national Medicaid 50th percentile but below the 75th percentile, and three measures were below the 25th percentile.

Table 3-40—UHC CP's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Ambulatory Care			
ED Visits/1,000[1]	--	53.34	★★★
Outpatient Visits/1,000	--	255.45	★
Enrollment by Product Line[2]			
0–19 years	--	0.28	--
20–44 years	--	0.47	--
45–64 years	--	0.25	--
65+ years	--	0.00	--
Frequency of Ongoing Prenatal Care			
<21 Percent[1]	--	23.80%	★
81+ Percent	--	27.48%	★
Inpatient Utilization—General Hospital/Acute Care[3]			
Total Inpatient Discharges/1,000	--	7.93	--
Total Inpatient Days/1,000	--	43.49	--
Total Inpatient Average Length of Stay	--	5.48	--
Total Medicine Discharges/1,000	--	3.37	--
Total Medicine Days/1,000	--	15.79	--

Table 3-40—UHC CP's HEDIS Results for Non-ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Total Medicine Average Length of Stay	--	4.68	--
Total Surgery Discharges/1,000	--	2.10	--
Total Surgery Days/1,000	--	20.81	--
Total Surgery Average Length of Stay	--	9.92	--
Total Maternity Discharges/1,000	--	2.96	--
Total Maternity Days/1,000	--	8.29	--
Total Maternity Average Length of Stay	--	2.80	--
Mental Health Utilization[3]			
Mental Health Utilization—Total (Any Services)	--	9.87%	--
Mental Health Utilization—Total (Inpatient Services)	--	0.60%	--
Mental Health Utilization—Total (Intensive Outpatient Services)	--	0.06%	--
Mental Health Utilization—Total (Ambulatory/ED Visits)	--	9.60%	--
Plan All-Cause Readmissions			
PCR Total[1,2,4]	--	13.79%	--

[1]*A lower rate indicates better performance for this measure. For performance level evaluation, if the measure had applicable benchmarks, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[3]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

[4]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Commercial weights for the non-ABD population.*

EFFECTIVENESS OF CARE

UHC CP's Effectiveness of Care non-ABD performance measure results are shown in Table 3-41. UHC CP only reported applicable HEDIS 2015 rates for 10 indicators in this domain. One indicator was ranked at or above the national Medicaid 75th percentile but below the 90th percentile, three indicators were at or above the 50th percentile but below the 75th percentile, and five indicators were below the 50th percentile.

Table 3-41—UHC CP's HEDIS Results for Non-ABD Measures Under Effectiveness of Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	--	30.30%	--	★
Adult BMI Assessment				
Adult BMI Assessment	--	80.29%	--	★★★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	--	86.53%	--	★★
Digoxin	--	NA	--	--
Diuretics	--	88.69%	--	★★★
Total	--	86.64%	--	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	--	54.55%	--	★★★★
Effective Continuation Phase Treatment	--	32.58%	--	★★
Colorectal Cancer Screening[1]				
Colorectal Cancer Screening	--	25.36%	--	--
Follow-Up After Hospitalization for Mental Illness				
7 Days	--	24.47%	--	★
30 Days	--	47.87%	--	★
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	--	NA	--	--
Continuation Phase	--	NA	--	--
Medication Management for People With Asthma				
Medication Compliance 50%	--	NA	--	--
Medication Compliance 75%	--	NA	--	--
Persistence of Beta Blocker Treatment After a Heart Attack				
Persistence of Beta Blocker Treatment After a Heart Attack	--	NA	--	--
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	--	NA	--	--

Table 3-41—UHC CP's HEDIS Results for Non-ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Bronchodilator	--	NA	--	--
Use of Appropriate Medications for People With Asthma				
5–11 years	--	NA	--	--
12–18 years	--	NA	--	--
19–50 years	--	NA	--	--
51–64 years	--	NA	--	--
Total	--	NA	--	--

[1] *Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Conclusions and Recommendations

Compared to HEDIS 2014, no HEDIS 2015 rates reported a statistically significant increase, and two measure rates showed a statistically significant decrease. Of the 67 non-ABD rates compared to national HEDIS 2014 Medicaid percentiles, less than a third of UHC CP's measure results ranked above the 25th percentile, and only eight ranked above the 50th percentile.

For HEDIS 2015, two non-ABD measure rates showed a significant decline from the prior year. HSAG recognizes that UHC CP has been implementing various improvement initiatives targeting the *Well-Child Visits in the First 15 Months of Life, Comprehensive Diabetes Care,* and *Controlling High Blood Pressure* measures. Nonetheless, two of these measures, along with other measures, fell below the national 25th percentile. HSAG recommends that UHC CP focus on the following measures across different categories for improvement:

- Children's Preventive Care:
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Well-Child Visits in the First 15 Months of Life*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health: All measures
- Care for Chronic Conditions:
  - *Comprehensive Diabetes Care—HbA1c Control* and *Blood Pressure Control (<140/90)*
- Access to Care: All measures
- Utilization:
  - *Ambulatory Care—Outpatient Visits*
  - *Frequency of Ongoing Prenatal Care*
- Effectiveness of Care:
  - *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
  - *Follow-Up After Hospitalization for Mental Illness*

ABD HEDIS PERFORMANCE MEASURES RESULTS

CHILDREN'S PREVENTIVE CARE

UHC CP's Children's Preventive Care ABD performance measure results are shown in Table 3-42. UHC CP did not have applicable HEDIS 2014 or 2015 rates for *Childhood Immunization Status* and *Well-Child Visits in the First 15 Months of Life*, so percentage point change was not shown and rates are shown as *NA*. Within this domain, two measure rates were at or above the 25th percentile but below the 50th percentile, and six measure rates were below the 25th percentile.

Table 3-42—UHC CP's HEDIS Results for ABD Measures Under Children's Preventive Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	--	36.57%	--	★
Childhood Immunization Status				
DTaP	--	NA	--	--
IPV	--	NA	--	--
MMR	--	NA	--	--
HiB	--	NA	--	--
Hepatitis B	--	NA	--	--
VZV	--	NA	--	--
Pneumococcal Conjugate	--	NA	--	--
Hepatitis A	--	NA	--	--
Rotavirus	--	NA	--	--
Influenza	--	NA	--	--
Combination #2	--	NA	--	--
Combination #3	--	NA	--	--
Combination #4	--	NA	--	--
Combination #5	--	NA	--	--
Combination #6	--	NA	--	--
Combination #7	--	NA	--	--
Combination #8	--	NA	--	--
Combination #9	--	NA	--	--
Combination #10	--	NA	--	--
Immunization for Adolescents				
Meningococcal	--	45.45%	--	★
Tdap/Td	--	49.09%	--	★
Combined	--	41.82%	--	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation	--	53.87%	--	★★
Counseling for Nutrition	--	51.03%	--	★★
Counseling for Physical Activity	--	34.02%	--	★

Table 3-42—UHC CP's HEDIS Results for ABD Measures Under Children's Preventive Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Well-Child Visits in the First 15 Months of Life				
0 Visits[1]	--	NA	--	--
6 or More Visits	--	NA	--	--
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	--	63.36%	--	★

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

WOMEN'S HEALTH

UHC CP's Women's Health ABD performance measure results are shown in Table 3-43. One measure rate in this domain was at or above the 50th percentile but below the 75th percentile, and three measure rates fell below the 25th percentile.

Table 3-43—UHC CP's HEDIS Results for ABD Measures Under Women's Health				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	--	58.68%	--	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	--	48.94%	--	★
Chlamydia Screening in Women				
16–20 Years	--	NA	--	--
21–24 Years	--	41.30%	--	★
Total	--	31.51%	--	★
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	--	NA	--	--

CARE FOR CHRONIC CONDITIONS

UHC CP's Care for Chronic Conditions ABD performance measure results are shown in Table 3-44. Among the *Comprehensive Diabetes Care* indicators, one rate showed statistically significant increase (*Blood Pressure Control (<140/90)*: 12.50 percentage points). *Controlling High Blood Pressure* also reflected a statistically significant increase (12.29 percentage points). One measure rate was at or above the 90th percentile, three measure rates were at or above the 75th percentile but below the 90th percentile, and four measure rates were at or above the 50th percentile but below the 75th percentile.

Table 3-44—UHC CP's HEDIS Results for ABD Measures Under Care for Chronic Conditions				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	84.20%	84.20%	0.00	★★★
HbA1c Poor Control (>9.0%)[1]	34.38%	31.08%	-3.30	★★★★
HbA1c Control (<8.0%)	58.16%	59.38%	+1.22	★★★★★
HbA1c Control (<7.0%)	41.08%	38.50%	-2.58	★★★
Eye Exam	62.85%	64.76%	+1.91	★★★★
Nephropathy	85.24%	85.24%	0.00	★★★★
Blood Pressure Control (<140/90)	50.87%	63.37%	**+12.50**	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	45.48%	57.77%	**+12.29**	★★★

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

ACCESS TO CARE

UHC CP's Access to Care ABD performance measure results are shown in Table 3-45. All four indicators of the *Adults' Access to Preventive/Ambulatory Health Services* measure reported a statistically significant decrease from the previous year. However, two measure rates were at or above the 90th percentile, one measure was at or above the 75th percentile but below the 90th percentile, and one measure rate was at or above the 50th percentile but below the 75th percentile. Seven measure rates fell below the 25th percentile.

Table 3-45—UHC CP's HEDIS Results for ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 years	87.47%	83.94%	**-3.53**	★★★
45–64 years	93.61%	92.13%	**-1.48**	★★★★
65+ years	96.50%	95.61%	**-0.89**	★★★★★
Total	94.07%	92.71%	**-1.36**	★★★★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 months	--	NA	--	--
25 months–6 years	--	73.47%	--	★
7–11 years	--	72.73%	--	★
12–19 years	--	73.18%	--	★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	--	31.77%	--	★

Table 3-45—UHC CP's HEDIS Results for ABD Measures Under Access to Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Engagement of AOD Treatment	--	4.56%	--	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	--	48.48%	--	★
Postpartum Care	--	51.52%	--	★

UTILIZATION

UHC CP's Utilization ABD performance measure results are shown in Table 3-46. One measure rate in this domain was at or above the national Medicaid 90th percentile, one measure rate was at or above the 50th percentile but below the 75th percentile, and two measure rates were below the 25th percentile.

Table 3-46—UHC CP's HEDIS Results for ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Ambulatory Care			
ED Visits/1,000[1]	63.70	63.79	★★★
Outpatient Visits/1,000	798.97	780.76	★★★★★
Enrollment by Product Line[2]			
0–19 years	--	0.06	--
20–44 years	--	0.14	--
45–64 years	--	0.31	--
65+ years	--	0.48	--
Frequency of Ongoing Prenatal Care			
<21 Percent[1]	--	66.67%	★
81+ Percent	--	9.09%	★
Inpatient Utilization—General Hospital/Acute Care[3]			
Total Inpatient Discharges/1,000	19.18	18.97	--
Total Inpatient Days/1,000	183.98	170.29	--
Total Inpatient Average Length of Stay	9.59	8.98	--
Total Medicine Discharges/1,000	15.00	15.12	--
Total Medicine Days/1,000	137.52	126.89	--
Total Medicine Average Length of Stay	9.17	8.39	--
Total Surgery Discharges/1,000	4.05	3.67	--
Total Surgery Days/1,000	46.11	43.02	--

Table 3-46—UHC CP's HEDIS Results for ABD Measures Under Utilization			
	HEDIS 2014 Rate	HEDIS 2015 Rate	2015 Performance Level
Total Surgery Average Length of Stay	11.37	11.71	--
Total Maternity Discharges/1,000	0.25	0.36	--
Total Maternity Days/1,000	0.68	0.77	--
Total Maternity Average Length of Stay	2.74	2.15	--
Mental Health Utilization[3]			
Mental Health Utilization—Total (Any Services)	--	17.90%	--
Mental Health Utilization—Total (Inpatient Services)	--	1.58%	--
Mental Health Utilization—Total (Intensive Outpatient Services)	--	0.02%	--
Mental Health Utilization—Total (Ambulatory/ED Visits)	--	17.04%	--
Plan All-Cause Readmissions			
PCR Total[1,2,4]	13.56%	15.61%	--

[1]*A lower rate indicates better performance for this measure. For performance level evaluation, if the measure had applicable benchmarks, HSAG reversed the order of the national percentiles to be consistently applied to the measure as with the other HEDIS measures. For example, the 25th percentile (a lower rate) was reversed to become the 75th percentile, indicating better performance.*

[2]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[3]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

[4]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Commercial weights for the non-ABD population.*

EFFECTIVENESS OF CARE

UHC CP's Effectiveness of Care ABD performance measure results are shown in Table 3-47. Five measure rates in this domain were at or above the national Medicaid 90th percentile, three rates were at or above the 75th percentile but below the 90th percentile, three measures were at or above the 50th percentile but below the 75th percentile, and eight measures were below the 50th percentile.

Table 3-47—UHC CP's HEDIS Results for ABD Measures Under Effectiveness of Care

	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	--	75.64%	--	★★★★★
Adult BMI Assessment				
Adult BMI Assessment	--	82.99%	--	★★★
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	--	91.51%	--	★★★★
Digoxin	--	51.37%	--	★
Diuretics	--	92.40%	--	★★★★★
Total	--	90.87%	--	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	--	46.37%	--	★★
Effective Continuation Phase Treatment	--	40.48%	--	★★★★
Care for Older Adults[1]				
Advance Care Planning	--	60.65%	--	--
Medication Review	--	79.40%	--	--
Functional Status Assessment	--	69.68%	--	--
Pain Assessment	--	81.71%	--	--
Colorectal Cancer Screening[1]				
Colorectal Cancer Screening	--	47.10%	--	--
Follow-Up After Hospitalization for Mental Illness				
7 Days	--	37.22%	--	★★
30 Days	--	56.11%	--	★★
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	--	NA	--	--
Continuation Phase	--	NA	--	--
Medication Management for People With Asthma				
Medication Compliance 50%	--	70.63%	--	★★★★★
Medication Compliance 75%	--	46.85%	--	★★★★★

Table 3-47—UHC CP's HEDIS Results for ABD Measures Under Effectiveness of Care				
	HEDIS 2014 Rate	HEDIS 2015 Rate	Percentage Point Change	2015 Performance Level
Medication Reconciliation Post-Discharge[1]				
Medication Reconciliation Post-Discharge	--	21.81%	--	--
Persistence of Beta Blocker Treatment After a Heart Attack				
Persistence of Beta Blocker Treatment After a Heart Attack	--	94.37%	--	★★★★
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	--	70.83%	--	★★★
Bronchodilator	--	83.33%	--	★★
Use of Appropriate Medications for People With Asthma				
5–11 years	--	NA	--	--
12–18 years	--	NA	--	--
19–50 years	--	77.65%	--	★★★
51–64 years	--	63.92%	--	★
Total	--	72.22%	--	★
Use of Spirometry Testing in the Assessment and Diagnosis of COPD				
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	--	28.57%	--	★★

[1]Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.

Conclusions and Recommendations

Compared to HEDIS 2014, two HEDIS 2015 rates reported a statistically significant increase, and four measure rates showed a statistically significant decrease. Of the 54 ABD rates compared to national HEDIS 2014 Medicaid percentiles, approximately half of UHC CP's measure results ranked above the 50th percentile, and nine ranked above the 90th percentile.

For HEDIS 2015, four of the ABD measure rates showed a significant decline from the prior year. HSAG also noted that quite a few HEDIS 2015 performance measure rates fell below the national 25th percentile. HSAG recommends that UHC CP focus on the following measures across different categories for improvement; since some of these measures are also identified as opportunities for improvement for the non-ABD populations, UHC CP should develop integrative strategies for various populations:

- Children's Preventive Care:
  - *Adolescent Well-Care Visits*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

- Women's Health:
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women—21–24 Years and Total*
- Access to Care:
  - *Children and Adolescents' Access to Primary Care Practitioners*
  - *Initiation and Engagement of Alcohol and Other Drug Treatment*
  - *Prenatal and Postpartum Care*
- Utilization:
  - *Frequency of Ongoing Prenatal Care*
- Effectiveness of Care:
  - *Annual Monitoring for Patients on Persistent Medications—Digoxin*
  - *Use of Appropriate Medications for People With Asthma—51–64 Years* and *Total*

Validation of Performance Improvement Projects

The purpose of a PIP is to achieve, through ongoing measurements and interventions, meaningful improvement sustained over time in clinical and nonclinical areas. For the 2015 validation cycle, the health plans had initiated new PIPs and had not yet progressed to reporting results.

AlohaCare QUEST Integration

For validation year 2015, AlohaCare submitted two State-mandated PIPs for validation: *All-Cause Readmissions* and *Diabetes Care*. The PIP topics addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to, care and services.

In April 2015, AlohaCare submitted modules 1 and 2 for initial review. HSAG provided written feedback followed by technical assistance calls to discuss any necessary revisions. AlohaCare resubmitted Modules 1 and 2 for a secondary review throughout the months of May and June, and HSAG conducted a final review and provided final validation feedback. In July 2015, AlohaCare progressed to submitting Module 3. HSAG conducted an initial review and provided feedback. The health plan required technical assistance and needed to make revisions to each Module 3 submitted. AlohaCare resubmitted Module 3 for each PIP topic with the identified deficiencies corrected, and HSAG provided its final validation feedback.

The focus of the *All-Cause Readmissions* PIP was to decrease readmissions related to poor quality outcomes following the initial discharge. The focus of the *Diabetes Care* PIP was to increase quality outcomes through timely access to care. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Table 3–48 outlines AlohaCare's SMART Aim measure for each PIP.

Table 3–48—SMART Aim Measures

PIP Topic	SMART Aim Measure
All-Cause Readmissions	Readmissions within 30 days at The Queen's Medical Center.
Diabetes Care	Eye exams due within the measurement year for diabetic members ages 18–75 seen at Waimanalo Health Center.

Results

AlohaCare completed and submitted modules 1 through 3 (PIP Initiation, SMART Aim Data Collection, and Intervention Determination). Upon review, HSAG identified opportunities for improvement that included:

- Providing data to support the narrowed focus.

- Correctly stating the SMART Aim.
- Specifying key drivers.
- Choosing detailed, active interventions.
- Providing an appropriate data collection methodology.
- Completing an accurate run chart.
- Correctly defining meaningful and sustained improvement.
- Including all of the required team members.
- Providing the process for selecting subprocesses and failure modes.
- Describing failure modes, causes, and effects that clearly link back to the PIP's focus.
- Describing the failure modes ranking process.

After receiving technical assistance from HSAG, AlohaCare revised its modules and resubmitted them for final validation. AlohaCare met the criteria for the three completed modules.

Table 3–49—Status of the *All-Cause Readmissions* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Table 3–50—Status of the *Diabetes Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Key Drivers

Key drivers are factors that contribute directly to achieving the SMART Aim. AlohaCare's identification of key drivers and subsequent selection of appropriate interventions to address them are necessary steps to improve outcomes and essential to the health plan's overall success.

For the *All-Cause Readmissions* PIP, AlohaCare identified key drivers that included:

- Timeliness of follow-up with primary care provider (PCP).
- Inability to reach members due to out-of-date contact information.

- Member understanding of discharge instructions.
- Notification to PCPs of member admissions/discharges.
- Support for transition of members from hospital to home.
- Hospital and health plan collaboration for members transitioning to home.

For the *Diabetes Care* PIP**,** AlohaCare identified key drivers that included:

- Early identification of high-risk members.
- Member engagement.
- Provider engagement.
- Access to resources.
- Plan engagement.

Failure Modes and Interventions

Through its process mapping and FMEA, AlohaCare identified the following failure modes and interventions that will potentially be tested in Module 4 using PDSA.

For the *All-Cause Readmissions* PIP, AlohaCare identified the following failure modes:

- Member not aware of discharge instructions to follow up with PCP.
- Member did not schedule a follow-up visit with PCP.
- Member does not have the means to follow up with PCP.
- Member does not understand the discharge instructions.
- PCP not aware that the member was admitted to/discharged from the hospital.
- Member not established with a PCP.
- Member did not receive a copy of the discharge instructions.
- Member's first language is not English.
- The discharging facility does not consistently send a copy of the discharge instructions to PCPs.

Potential interventions included:

- Assisting members with scheduling a PCP visit.
- Formalizing the process/work flow for referrals to service coordinators.
- Sending a copy of the discharge instructions to the member.
- Sending discharge instructions to the PCP.
- Implementing a feedback technique for discharge instructions with members.

For the *Diabetes Care* PIP, AlohaCare identified the following failure modes:

- Member had other priorities.
- Member forgot to attend eye exam appointment.
- Educational material is not effective.

- Member did not receive educational materials/information regarding exam value.
- No process in place for calling Level 1 disease management members.
- Member is not reachable by Waimanalo Health Center.
- Member is not reachable by AlohaCare nurse.

Potential interventions included:

- Improving follow-up and rescheduling process between clinic and health plan.
- Improving the educational materials provided to engage members.
- Confirming most up-to-date member demographics.
- Referring members detected as unreachable by the clinic to the health plan for follow-up by disease management nurse.

Hawaii Medical Service Association QUEST Integration

For validation year 2015, HMSA submitted two State-mandated PIPs for validation: *All-Cause Readmissions* and *Diabetes Care*. The PIP topics addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to, care and services.

In April 2015, HMSA submitted modules 1 and 2 for initial review. HSAG provided written feedback followed by technical assistance calls to discuss any necessary revisions. HMSA resubmitted modules 1 and 2 for a secondary review in June, and HSAG conducted a final review and provided final validation feedback. In July 2015, HMSA progressed to submitting Module 3. HSAG conducted an initial review and provided feedback. HMSA resubmitted Module 3 for each PIP topic with the identified deficiencies corrected, and HSAG provided its final validation feedback. HMSA had three technical assistance sessions with HSAG; the first two were in May 2015, and the third was in June 2015.

The focus of the *All-Cause Readmissions* PIP was to decrease readmissions related to poor quality outcomes following initial discharge. The focus of the *Diabetes Care* PIP was to increase member understanding on the importance of timely access to care. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Table 3–51 outlines HMSA's SMART Aim measure for each PIP.

Table 3–51—SMART Aim Measures

PIP Topic	SMART Aim Measure
All-Cause Readmissions	Readmissions within 30 days for members who had at least one secondary readmission in a five-year look-back period and were provided community services by Hawaii Independent Physician's Organization, Pacific Health Partners, or Hawaii Physician Organization.
Diabetes Care	Members seen at Bay Clinic or Kalihi Palama Health Center whose latest HbA1c test within the prior 12 months indicated a control value of less than 9.

Results

HMSA completed and submitted modules 1 through 3 (PIP Initiation, SMART Aim Data Collection, and Intervention Determination). Upon review, HSAG identified opportunities for improvement that included:

- Providing a narrowed focus.
- Including data to support the selection of the focus.
- Correctly stating the SMART Aim.
- Defining a targeted population.
- Using data other than claims.
- Submitting a data collection tool.

- Including a run chart with all of the required components.
- Correctly defining meaningful and sustained improvement.
- Providing the process for selecting subprocesses and failure modes.
- Clearly linking the failure modes, causes, and effects to the PIP's focus.
- Providing rationale for selecting some of the failure modes for interventions.

After receiving technical assistance from HSAG, HMSA revised its modules and resubmitted them for final validation. HMSA met the criteria for the three completed modules.

Table 3–52—Status of the *All-Cause Readmissions* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Table 3–53—Status of the *Diabetes Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Key Drivers

Key drivers are factors that contribute directly to achieving the SMART Aim. HMSA's identification of key drivers and subsequent selection of appropriate interventions to address them are necessary steps to improve outcomes and essential to the health plan's overall success.

For the *All-Cause Readmissions* PIP, HMSA identified key drivers that included:

- Coordination of information between care providers.
- Convenience/access to community providers.
- Hospital discharge process.
- Timeliness of aftercare appointments.
- Member knowledge.
- Hospital-acquired conditions.

For the *Diabetes Care* PIP, HMSA identified key drivers for members that included:

- Knowledge/understanding of diabetes and potential for complications.
- Adherence to medication.
- Lack of regular touch points.
- Treatment/medication intensification.
- Lifestyle factors.

Failure Modes and Interventions

Through its process mapping and FMEA, HMSA identified the following failure modes and interventions that will potentially be tested in Module 4 using PDSA.

For the *All-Cause Readmissions* PIP, HMSA identified the following failure modes:

- Provider only treating those who come in for a follow-up appointment.
- Provider does not render the service or refer due to provider lack of awareness of importance of need.
- Provider does not render the service or refer due to provider lack of awareness of resources available.
- Provider does not render the service or refer due to lack of resources.
- Provider does not render the service or refer due to member refusal.
- Provider does not render the service or refer due to provider not feeling equipped to address the need.
- Data on needs were collected, but immediate needs not prioritized for follow-up.
- Not able to contact the member.
- No hand-off of information.
- Need not identified.

HMSA identified the following potential intervention:

- Provide longitudinal information to providers on high-risk members to underscore the need for comprehensive assessment and plan.

For the *Diabetes Care* PIP, HMSA identified the following failure modes:

- Member's medication regimen is not changed according to medication guidelines.
- Member's medication adherence diminishes and stops because the member does not understand the reason for medication.
- Member's medication adherence diminishes and stops because the member does not have reliable medication-taking habits.
- Member does not pick up refill.
- Member is not motivated to make lifestyle changes.
- Member decides to stop taking medications because the member is not comfortable with idea of medication.

- Member decides to stop taking medications because the member experiences side effects or drug reactions.
- Member's lifestyle changes are not sustained because there is no social support for change or the social support encourages the status quo.
- Member's lifestyle changes are not sustained because there is no way for the patient to track success.

Potential interventions included:

- HMSA will provide physicians with a tool that shows how long it has been since the members included in their caseload have had their medication changed.
- HMSA's adherence toolkit will encourage conversations about medications and optimal ways to have those conversations.
- HMSA's adherence toolkit will include tools and provider education about reliable medication-taking habits.
- HMSA will launch a mail order refill for the QUEST line of business.
- HMSA's disease management program will provide members with information about diabetes and the need for lifestyle modification.

Kaiser Permanente Hawaii QUEST Integration

For validation year 2015, Kaiser submitted two State-mandated PIPs for validation: *All-Cause Readmissions* and *Diabetes Care*. The PIP topics addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to, care and services.

In April 2015, Kaiser submitted modules 1 and 2 for initial review. HSAG provided written feedback followed by a technical assistance call to discuss any necessary revisions. Kaiser resubmitted modules 1 and 2 for a secondary review in May, and HSAG conducted a final review and provided final validation feedback. In July 2015, Kaiser progressed to submitting Module 3. HSAG conducted an initial review and provided feedback. Kaiser resubmitted Module 3 for each PIP topic with the identified deficiencies corrected, and HSAG provided its final validation feedback. Kaiser had one technical assistance call with HSAG in May 2015.

The focus of the *All-Cause Readmissions* PIP was to decrease readmissions related to poor quality outcomes following the initial discharge. The focus of the *Diabetes Care* PIP was to increase member understanding on the importance of timely access to care. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Table 3–54 outlines Kaiser's SMART Aim measure for each PIP.

Table 3–54—SMART Aim Measures

PIP Topic	SMART Aim Measure
All-Cause Readmissions	Readmissions within 30 days at Kaiser Foundation Hospital—Moanalua.
Diabetes Care	Diabetic members with an HbA1c < 8 who have Provider A, B, or C as their PCP.

Results

Kaiser completed and submitted modules 1 through 3 (PIP Initiation, SMART Aim Data Collection, and Intervention Determination). Upon review, HSAG identified opportunities for improvement that included:

- Providing data to support the narrowed focus.
- Identifying all required team members.
- Documenting a correctly stated SMART Aim and Global Aim.
- Specifying the targeted population.
- Correctly defining the SMART Aim measure, including a run chart with all of the components.
- Documenting rationale for selecting the goal.
- Identifying the providers in the PIP.
- Providing the team's process for selecting subprocesses for FMEA, including subprocesses that were from the process map.

- Describing the priority ranking process.

After receiving technical assistance from HSAG, Kaiser revised its modules and resubmitted them for final validation. Kaiser met the criteria for the three completed modules.

Table 3–55—Status of the *All-Cause Readmissions* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Table 3–56—Status of the *Diabetes Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Key Drivers

Key drivers are factors that contribute directly to achieving the SMART Aim. Kaiser's identification of key drivers and subsequent selection of appropriate interventions to address them are necessary steps to improve outcomes and essential to the health plan's overall success.

For the *All-Cause Readmissions* PIP, Kaiser identified key drivers that included:

- Discharge instructions/education.
- Member barriers.
- Follow-up/access.
- Care coordination between services.
- Medications.

For the *Diabetes Care* PIP, Kaiser identified key drivers that included:

- Medication.
- Continuity of care.
- Member education and engagement.

- Provider awareness.
- Access.

Failure Modes and Interventions

Through its process mapping and FMEA, Kaiser identified the following failure modes and interventions that will potentially be tested in Module 4 using PDSA.

For the *All-Cause Readmissions* PIP, Kaiser identified the following failure modes:

- Member does not answer calls or return messages.
- Member does not understand discharge medication instructions.
- Member did not pick up discharge medications.
- Discharge medication list does not match member's medication regimen at home.
- Member never schedules hospital follow-up appointment.
- Member does not attend scheduled appointment.
- Member does not have a telephone or telephone service.
- Member did not receive a copy of discharge medication instructions.
- Contact number not verified prior to discharge.
- Hospital follow-up appointment was not scheduled prior to discharge.
- Member did not provide correct telephone number.
- Appointment not scheduled due to clinic scheduling issues.

Potential interventions included:

- Chart review to assess for risk of readmission and assess if discharge medications were picked up and confirm member attended hospital follow-up appointment. If member missed appointment, chart review will be performed to assess if service coordinator should visit the member's home.
- Discharge medication instructions and comprehensive medication review will occur during post-discharge follow-up telephone call. Medication reconciliation will be performed to reduce duplicate medications.

For the *Diabetes Care* PIP, Kaiser identified the following failure modes:

- Member does not order medication refills.
- Member does not pick up medication refills from clinic.
- Member does not take medications.
- Member takes several medications and each medication has a different refill date.
- Member does not answer calls or return messages.
- Member forgets to take medication.
- Member not interested or engaged in self-management.
- Member does not "comply" with self-management instructions.

- Member does not understand self-management instructions (handouts).
- Telephone number listed in medical record is not accurate.
- Member does not have a telephone or telephone service.
- Member's family not supporting member's self-care efforts.
- Member not provided with information about the importance of self-management.

Potential interventions included:

- Dispense 90-day supply of medication.
- Send medication refills to the member via mail.
- Assess barriers to medication compliance (e.g., intolerance to medication or side effects).

'Ohana Health Plan QUEST Integration

For validation year 2015, 'Ohana submitted two State-mandated PIPs for validation: *All-Cause Readmissions* and *Diabetes Care*. The PIP topics addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to, care and services.

In April 2015, 'Ohana submitted modules 1 and 2 for initial review. HSAG provided written feedback followed by a technical assistance call to discuss any necessary revisions. 'Ohana resubmitted modules 1 and 2 for a secondary review in June, and HSAG conducted a final review and provided final validation feedback. In July 2015, 'Ohana progressed to submitting Module 3. HSAG conducted an initial review and provided feedback. 'Ohana resubmitted Module 3 for each PIP topic with the identified deficiencies corrected, and HSAG provided its final validation feedback. 'Ohana had one technical assistance call with HSAG in May 2015.

The focus of the *All-Cause Readmissions* PIP was to decrease readmissions related to poor quality outcomes following the initial discharge. The focus of the *Diabetes Care* PIP was to increase member understanding on the importance of timely access to care. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Table 3–57 outlines 'Ohana's SMART Aim measure for each PIP.

Table 3–57—SMART Aim Measures

PIP Topic	SMART Aim Measure
All-Cause Readmissions	Members discharged from the hospital who had a primary admitting diagnosis of heart failure or diabetes and had a readmission to the hospital for any reason within 30 days.
Diabetes Care	Diabetic members 18–75 years of age who have PCP-A or PCP-B as their primary care provider and had an annual diabetic retinal exam.

Results

'Ohana completed and submitted modules 1 through 3 (PIP Initiation, SMART Aim Data Collection, and Intervention Determination). Upon review, HSAG identified opportunities for improvement that included:

- Providing how the topic aligns with the State's quality strategy.
- Including the required team members.
- Correctly stating the SMART Aim.
- Identifying improvement strategies in the SMART Aim.
- Including an appropriate SMART Aim measure.
- Providing a tool that captures all data elements for the PIP.
- Revising the run chart.
- Including the process for selecting subprocesses or failure modes.
- Providing more clearly defined key drivers.

- Documenting interventions that have the potential to be tested for the PIP.

After receiving technical assistance from HSAG, ‘Ohana revised its modules and resubmitted them for final validation. ‘Ohana met the criteria for the three completed modules.

Table 3–58—Status of the *All-Cause Readmissions* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Table 3–59—Status of the *Diabetes Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Key Drivers

Key drivers are factors that contribute directly to achieving the SMART Aim. ‘Ohana’s identification of key drivers and subsequent selection of appropriate interventions to address them are necessary steps to improve outcomes and essential to the health plan’s overall success.

For the *All-Cause Readmissions* PIP, ‘Ohana identified key drivers that included:

- Care coordination during transition out of the hospital.
- PCP awareness.
- Member awareness.
- Member characteristics.
- Chronic disease management.

For the *Diabetes Care* PIP, ‘Ohana identified key drivers that included:

- Provider awareness.
- Provider availability.
- Member engagement.
- Member outreach.
- Lack of transportation.

Failure Modes and Interventions

Through its process mapping and FMEA, 'Ohana identified the following failure modes and interventions that will potentially be tested in Module 4 using PDSA.

For the *All-Cause Readmissions* PIP, 'Ohana identified the following failure modes:

- No follow-up is made after a missed appointment to schedule a new appointment.
- Member forgets to schedule a follow-up appointment with PCP after hospital discharge.
- Member not provided with information about the importance of following up with PCP.
- Member forgets about the follow-up appointment with PCP.
- Member does not understand the importance of following up with PCP.
- Follow-up appointment was not scheduled upon discharge from the hospital.
- Member does not have transportation to keep the appointment.
- PCP does not reach out to member to schedule a follow-up appointment.

Potential interventions included:

- Disease management nurse calling members to see if they made it to their scheduled appointment. Assess barriers that prevented members from making it to their appointment.
- Disease management nurse calling members to remind them to schedule an appointment or assist them with scheduling an appointment with their PCP.
- Disease management nurse calling members and educating them on the importance of follow-up with PCP.

For the *Diabetes Care* PIP, 'Ohana identified the following failure modes:

- Member does not understand the information provided.
- Scheduling process too difficult for member.
- Member forgets about the diabetic retinal exam appointment.
- Eye care professional (optometrist or ophthalmologist) not offering convenient hours.
- No follow-up is made after missed appointment to schedule a new time.
- Member does not have transportation to keep the appointment.
- Member's first language is not English.
- Scheduling assistance not provided by PCP.
- Member not provided with information about the importance of diabetic retinal exam.

Potential interventions included:

- PCP outreach to members to pique their interest in learning the importance of a diabetic retinal exam.
- Vendor (First Vitals) to bring screening machine to perform member's diabetic retinal exam at the PCP office.
- First Vitals to call members and remind them of their upcoming appointment one business day prior.

'Ohana Health Plan Community Care Services Program

For validation year 2015, 'Ohana CCS submitted two State-mandated PIPs for validation: *Follow-Up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*. The PIP topics addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to, care and services.

In April 2015, CCS submitted modules 1 and 2 for initial review. HSAG provided written feedback followed by a technical assistance call to discuss any necessary revisions. CCS resubmitted modules 1 and 2 for a secondary review in June, and HSAG conducted a final review and provided final validation feedback. In July 2015, CCS progressed to submitting Module 3. HSAG conducted an initial review and provided feedback. CCS resubmitted Module 3 for each PIP topic with the identified deficiencies corrected, and HSAG provided its final validation feedback. CCS had one technical assistance call in May 2015.

The focus of the *Follow-Up After Hospitalization for Mental Illness* PIP was to increase quality outcomes through timely access to care. The focus of the *Initiation of Alcohol and Substance Abuse Treatment for Mental Illness* PIP was to increase quality outcomes through timely access to care and services. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Table 3–60 outlines CCS' SMART Aim measure for each PIP.

Table 3–60—SMART Aim Measures

PIP Topic	SMART Aim Measure
Follow-Up After Hospitalization for Mental Illness	Members 18 years of age and older who are assigned to the Community Case Management Agencies, North Shore Mental Health Inc., or Care Hawaii Inc., who were discharged from an inpatient psychiatric facility and had a follow-up appointment with a mental health provider within seven days of discharge.
Initiation of Alcohol and Substance Abuse Treatment	Members 18 years of age and older who were assigned to the Community Case Management Agencies, Care Hawaii Inc., or North Shore Mental Health Inc.; were discharged from an inpatient psychiatric facility; had an admitting diagnosis of alcohol or other drug dependence; and engaged in two AOD treatments within 30 days of treatment initiation.

Results

CCS completed and submitted modules 1 through 3 (PIP Initiation, SMART Aim Data Collection, and Intervention Determination). Upon review, HSAG identified opportunities for improvement that included:

- Providing a narrowed focus.
- Designating a role for each team member.
- Including a complete and accurate SMART Aim and Global Aim.
- Submitting a correct run chart.

- Providing the team's process for selecting the subprocesses to conduct FMEA.
- Completely defining the study population for the PIP.
- Correctly defining the SMART Aim measure.
- Including appropriate interventions.

After receiving technical assistance from HSAG, CCS revised its modules and resubmitted them for final validation. CCS met the criteria for the three completed modules.

Table 3–61—Status of the *Follow-Up After Hospitalization for Mental Illness* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Table 3–62—Status of the *Initiation of Alcohol and Substance Abuse Treatment* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Key Drivers

Key drivers are factors that contribute directly to achieving the SMART Aim. CCS' identification of key drivers and subsequent selection of appropriate interventions to address them are necessary steps to improve outcomes and essential to the health plan's overall success.

For the *Follow-Up After Hospitalization for Mental Illness* PIP, CCS identified key drivers that included:

- Lack of communication with member; e.g., homeless, no phone.
- Member does not show for appointments.
- Member refuses aftercare.
- Member unwilling to see other provider if his or her regular provider is not available within seven days.
- Provider is unwilling to accept members with Medicaid.
- Fewer providers in rural communities.
- Provider has no appointments available within seven days of member's discharge.

For the *Initiation of Alcohol and Substance Abuse Treatment* PIP**,** CCS identified key drivers that included:

- Lack of valid communication method with member; e.g., homeless, no phone, no way to contact members.
- Member does not show for appointments.
- Member refuses treatment.
- Provider is unwilling to accept members with Medicaid.
- Provider has no openings.

Failure Modes and Interventions

Through its process mapping and FMEA, CCS identified the following failure modes and interventions that will potentially be tested in Module 4 using PDSA.

For the *Follow-Up After Hospitalization for Mental Illness* PIP, CCS identified the following failure modes:

- Follow-up appointment was not scheduled upon discharge from the hospital.
- Member forgets about the follow-up appointment with behavioral health (BH) provider.
- No follow-up is made after missed appointment to schedule a new appointment.
- Member not provided with information about the importance of following up with BH provider after hospital discharge.
- Member forgets to schedule a follow-up appointment with a BH provider after hospital discharge.
- Member not interested in understanding the importance of following up with a BH provider after hospital discharge.
- Member does not have transportation to get to the appointment.

Potential interventions included:

- Behavioral health case manager engaging with members within 48 hours after hospital discharge.
- BH case manager reaching out to members in person or by phone to remind them of scheduled appointment with BH provider.
- BH case manager reaching out to members in person or by phone to check if members made it to their scheduled appointment and to assess barriers that may have prevented them from making it to their appointment.
- BH case manager assisting members with scheduling a new follow-up appointment.

For the *Initiation of Alcohol and Substance Abuse Treatment* PIP, CCS identified the following failure modes:

- Member is not willing to start AOD treatment.

- Member forgets about the appointment for AOD treatment.
- AOD treatment was not scheduled prior to discharge from the hospital.
- Member does not understand the importance of AOD treatment.
- No follow-up is made to schedule a new appointment after a missed appointment.
- Member relapses and is readmitted.
- Member's choice of provider for AOD treatment does not have an available appointment or opening.
- Member not provided with information about the importance of AOD treatment.
- Member forgets to schedule an appointment for AOD treatment.
- Member does not have transportation to get to the appointment.

Potential interventions included:

- BH case manager engaging with members within 48 hours after hospital discharge. Test 'Ohana quality improvement (QI) specialist following up with BH case manager to see if AOD treatment was completed and emphasize the value of BH case manager educating members on the importance of AOD treatment.
- BH case manager reaching out to members in person or by phone to remind them of the AOD treatment.
- BH case manager engaging with members within 48 hours after hospital discharge to emphasize the importance of scheduling an appointment for AOD treatment and assisting members as appropriate.

UnitedHealthcare Community Plan QUEST Integration

For validation year 2015, UHC CP submitted two State-mandated PIPs for validation: *All-Cause Readmissions* and *Diabetes Care*. The PIP topics addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to, care and services.

In April 2015, UHC CP submitted modules 1 and 2 for initial review. HSAG provided written feedback followed by a technical assistance call to discuss any necessary revisions. UHC CP resubmitted modules 1 and 2 for a secondary review in June, and HSAG conducted a final review and provided final validation feedback. In July 2015, UHC CP progressed to submitting Module 3. HSAG conducted an initial review and provided feedback. The health plan required technical assistance and needed to make revisions to each Module 3 submitted. UHC CP resubmitted Module 3 for each PIP topic with the identified deficiencies corrected, and HSAG provided its final validation feedback. UHC CP had one technical assistance call with HSAG in May 2015.

The focus of the *All-Cause Readmissions* PIP was to decrease readmissions related to poor quality outcomes following the initial discharge. The focus of the *Diabetes Care* PIP was to increase member understanding on the importance of timely access to care. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Table 3–63 outlines UHC CP's SMART Aim measure for each PIP.

Table 3–63—SMART Aim Measures

PIP Topic	SMART Aim Measure
All-Cause Readmissions	Readmissions within 30 days for members 18-64 years of age assigned to Kalihi Palama Health Center.
Diabetes Care	Bay Clinic Members with diabetes who had at least one HbA1c test in the past 12 months (rolling).

Results

UHC CP completed and submitted modules 1 through 3 (PIP Initiation, SMART Aim Data Collection, and Intervention Determination). Upon review, HSAG identified opportunities for improvement that included:

- Providing data to support the narrowed focus.
- Including external partners on the team.
- Correctly stating the SMART Aim.
- Using data other than claims.
- Correctly defining the SMART Aim measure.
- Using monthly or more frequent data collection.
- Providing a correctly plotted run chart.
- Including the team's process for selecting a subprocess to conduct FMEA.

- Describing the FMEA priority ranking process.
- Including appropriate interventions.

After receiving technical assistance from HSAG, UHC CP revised its modules and resubmitted them for final validation. UHC CP met the criteria for the three completed modules.

Table 3–64—Status of the *All-Cause Readmissions* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Table 3–65—Status of the *Diabetes Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act	Initiated in August 2015
5. PIP Conclusions	Targeted for July 2016

Key Drivers

Key drivers are factors that contribute directly to achieving the SMART Aim. UHC CP's identification of key drivers and subsequent selection of appropriate interventions to address them are necessary steps to improve outcomes and essential to the health plan's overall success.

For the *All-Cause Readmissions* PIP, UHC CP identified key drivers that included:

- Timely identification of acute inpatient stay.
- Right care at hospital.
- Identification of members at risk for readmission.
- Effective transitions to the community.
- Chronic disease management.

For the *Diabetes Care* PIP, UHC CP identified key drivers that included:

- Access-to-care issues: transportation and specialist availability.
- More complex comorbidities.
- Lack of member engagement with healthcare provider for diabetes.
- Lack of member knowledge/concern regarding the importance of HbA1c tests.

- Primary care provider (PCP) communication to members regarding the need for HbA1c test and HbA1c results.

Failure Modes and Interventions

Through its process mapping and FMEA, UHC CP identified the following failure modes and interventions that will potentially be tested in Module 4 using PDSA.

For the *All-Cause Readmissions* PIP, UHC CP identified the following failure modes:

- Member not adhering to medication plan.
- The member does not want to go to Kalihi Palama Health Center because he or she is established with a different PCP.
- Member is not accessible for outreach after discharge to complete post-discharge activities.
- Member does not understand discharge instructions.
- Member forgets about the PCP follow-up appointment.
- Member/guardian has difficulty following discharge/PCP instructions without more support.
- Member/guardian does not understand the importance of following discharge/PCP instructions.
- The member does not access available transportation to go to the PCP.
- Member does not feel that PCP follow-up is necessary.
- Gaps in discharge planning (including, if applicable, home- and community-based services and service coordination requirements, and PCP follow-up appointment).

Potential interventions included:

- Medication reconciliation program that includes education regarding the importance of medication adherence within seven days of discharge. Education regarding drug mail order delivery benefits.
- Collaborate with Kalihi Palama Health Center to identify members who are assigned to Kalihi Palama Health Center but are not established. Develop a process to reach out to members and reassign members to their established PCP. Develop a process during inpatient admission to ensure PCP designation is verified with the member before scheduling a PCP follow-up.
- Develop a program to find inaccessible members in the community. Collaborate with Kalihi Palama Health Center to obtain contact information for outreach.

For the *Diabetes Care* PIP, UHC CP identified the following failure modes:

- Member is not accessible for outreach.
- Member is not identified as being due for an HbA1c test.
- Member is not identified as having diabetes.
- Member does not have transportation to go to the clinic.
- Member does not understand the importance of HbA1c testing.
- Member forgets about the HbA1c appointment.

- Member does not feel that HbA1c testing is necessary.

Potential interventions included:

- Collaborative outreach with the health plan and Bay Clinic to members identified as having diabetes who are due for HbA1c tests.
- Monthly collaboration between the health plan and Bay Clinic to identify members with diabetes and members with diabetes who are due for an HbA1c test.
- Collaboration between the health plan and Bay Clinic to provide transportation assistance for the member.

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

AlohaCare QI

Results

Table 3-66 presents the 2015 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for AlohaCare QI.[3-1,3-2]

Table 3-66—Child Medicaid CAHPS Results *for* AlohaCare QI

Measure	2015 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	70.0%	★★★
Rating of All Health Care	65.1%	★★★
Rating of Personal Doctor	74.2%	★★★★
Rating of Specialist Seen Most Often	61.1%+	★+
Composite Measures		
Getting Needed Care	76.4%	★
Getting Care Quickly	80.4%	★
How Well Doctors Communicate	94.4%	★★★
Customer Service	77.0%	★

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

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

3-1 2015 represents the first year AlohaCare QI child members were surveyed; therefore, 2014 rates are not available for the health plan.

3-2 Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

The overall member satisfaction ratings revealed that AlohaCare QI scored:

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

Conclusions and Recommendations

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

RATING OF SPECIALIST SEEN MOST OFTEN

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

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

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

GETTING NEEDED CARE

Appropriate Healthcare Providers—The health plan should continue its efforts to ensure that patients are receiving care from physicians most appropriate to treat their conditions. Tracking

patients to ascertain that they are receiving effective, necessary care from those appropriate healthcare providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate healthcare providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive timely care.

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

GETTING CARE QUICKLY

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

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

CUSTOMER SERVICE

Customer Service Training Program—The health plan should ensure its customer service training program meets the needs of its unique work environment and members. An evaluation of the existing training program could be conducted to ensure the training topics and frequency of training are meeting the needs of its staff and members. Feedback from employees, managers, and business administrators on existing customer service training program and refresher training courses could be used to ensure staff are competent in their ability to respond to members' inquires and deal with difficult patient/member encounters An evaluation of the existing customer service training program will allow the health plan to identify potential gaps and areas where additional or more frequent training is needed and serve as a guide for implementing changes, if and where necessary. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but to implement a support structure when they are back on the job.

HMSA QI

Results

Table 3-67 presents the 2015 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for HMSA QI.[3-3,3-4]

Table 3-67—Child Medicaid CAHPS Results *for* HMSA QI

Measure	2015 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	74.3%	★★★★★
Rating of All Health Care	69.6%	★★★★★
Rating of Personal Doctor	76.7%	★★★★★
Rating of Specialist Seen Most Often	74.6%+	★★★★★
Composite Measures		
Getting Needed Care	84.5%	★★★
Getting Care Quickly	87.7%	★★
How Well Doctors Communicate	94.0%	★★★★
Customer Service	91.8%	★★★

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

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

The overall member satisfaction ratings revealed that HMSA QI scored:

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

Conclusions and Recommendations

Based on an evaluation of HMSA QI's results, the priority areas identified were *Getting Care Quickly* and *Getting Needed Care*. The following are recommendations of best practices and other

[3-3] 2015 represents the first year HMSA QI child members were surveyed; therefore, 2014 rates are not available for the health plan.

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

proven strategies that may be used or adapted by the health plan to target improvement in these areas.

GETTING CARE QUICKLY

Decreasing No-Show Appointments—The health plan should continue its effort to assist providers in addressing members with continual patterns of no-shows. In addition, the health plan could assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the health plan in determining additional potential resolutions outside of referring members to service coordinators.

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

GETTING NEEDED CARE

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

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

Kaiser QI

Results

Table 3-68 presents the 2015 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for Kaiser QI.[3-5,3-6]

Table 3-68—Child Medicaid CAHPS Results *for* Kaiser QI

Measure	2015 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	75.9%	★★★★★
Rating of All Health Care	72.0%	★★★★★
Rating of Personal Doctor	83.1%	★★★★★
Rating of Specialist Seen Most Often	77.6%+	★★★★★
Composite Measures		
Getting Needed Care	82.4%	★★
Getting Care Quickly	90.2%	★★★
How Well Doctors Communicate	96.5%	★★★★★
Customer Service	88.8%	★★★

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

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

The overall member satisfaction ratings revealed that Kaiser QI 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*.
- At or between the 75th and 89th percentiles on no measures.
- At or between the 50th and 74th percentiles on two measures: *Getting Care Quickly* and *Customer Service*.
- At or between the 25th and 49th percentiles on one measure, *Getting Needed Care.*
- Below the 25th percentile on no measures.

[3-5] 2015 represents the first year Kaiser QI child members were surveyed; therefore, 2014 rates are not available for the health plan.

[3-6] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

Conclusions and Recommendations

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

GETTING NEEDED CARE

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

GETTING CARE QUICKLY

Open Access Scheduling—The health plan should continue its current efforts toward developing an open access scheduling model that allows for appointment flexibility and for patients to receive same-day appointments. This type of model can be used to ensure physician supply and availability matches the demand for appointments, in turn increasing patient access to timely care.

CUSTOMER SERVICE

Customer Service Training Program—The health plan should ensure its customer service training program meets the needs of its unique work environment and members. An evaluation of the existing training program could be conducted to ensure the training topics and frequency of training are meeting the needs of its staff and members. Feedback from employees, managers, and business administrators on existing customer service training program and refresher training courses could be used to ensure staff are competent in their ability to respond to members' inquires and deal with difficult patient/member encounters An evaluation of the existing customer service training program will allow the health plan to identify potential gaps and areas where additional or more frequent training is needed and serve as a guide for implementing changes, if and where necessary. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but to implement a support structure when they are back on the job.

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

'Ohana QI

Results

Table 3-69 presents the 2015 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for 'Ohana QI.[3-7,3-8]

Table 3-69—Child Medicaid CAHPS Results *for* 'Ohana QI

Measure	2015 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	56.8%	★
Rating of All Health Care	54.7%	★
Rating of Personal Doctor	65.9%	★
Rating of Specialist Seen Most Often	69.0%	★★★
Composite Measures		
Getting Needed Care	76.0%	★
Getting Care Quickly	84.0%	★
How Well Doctors Communicate	90.6%	★★
Customer Service	79.0%	★

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

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

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

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

[3-7] 2015 represents the first year 'Ohana QI child members were surveyed; therefore, 2014 rates are not available for the health plan.

[3-8] Since NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, overall member satisfaction ratings (i.e., star ratings) cannot be assigned.

Conclusions and Recommendations

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

RATING OF HEALTH PLAN

Promote Quality Improvement Initiatives—The health plan should continue its efforts and implementation of organization-wide quality improvement initiatives. In addition to aligning quality improvement goals to the mission and goals of the health plan organization, the health plan can explore establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing quality improvement initiatives. Furthermore, the health plan should continue to monitor internal reporting on the progress of quality improvement to assess the effectiveness of these efforts.

RATING OF ALL HEALTH CARE

Access to Care—The health plan should continue its efforts to identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The health plan should attempt to reduce any hindrances a patient might encounter while seeking care.

Patient and Family Engagement Advisory Councils—Having recently established an advisory council composed of its members and key management staff, the health plan should continue its outreach to members informing them of the committee and encouraging participation. The health plan should monitor members and staff involvement in advisory councils to ensure the structure and process encourages ongoing dialogue and creative problem-solving between the health plan and its members, as well as explore other opportunities and functional roles that the council serves when evaluating its healthcare processes.

RATING OF PERSONAL DOCTOR

Maintain Truth in Scheduling—The health plan can request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit, as well as provide assistance or instructions to those physicians unfamiliar with this type of assessment. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it takes to complete the scheduled visit. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times. Additionally, by measuring the amount of time it takes to provide care, both health plans and physician offices can identify where streamlining opportunities exist.

Direct Patient Feedback—The health plan should continue its current efforts for obtaining direct patient feedback to improve patient satisfaction. Comment cards have been used and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Asking patients to describe what they liked most about the care they received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest. This direct feedback can be helpful in gaining a better understanding of the specific areas that are working well and areas which can be targeted for improvement.

Physician-Patient Communication—The health plan should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication which involves allowing the patient to discuss and share in the decision making process, as well as effectively communicating expectations and goals of healthcare treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication.

Improving Shared Decision Making—The health plan should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their healthcare. One key to a successful shared decision making model is ensuring that physicians are properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision making process, ensuring that physicians understand the importance of taking each patient's values into consideration, and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

GETTING CARE QUICKLY

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

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

Open Access Scheduling—The health plan should continue to encourage providers to adopt an open access scheduling model that can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for

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

GETTING NEEDED CARE

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

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

CUSTOMER SERVICE

Creating an Effective Customer Service Training Program—The health plan should ensure its customer service training program meets the needs of its unique work environment and members. An evaluation of the existing training program could be conducted to ensure the training topics and frequency of training are meeting the needs of its staff and members. Feedback from employees, managers, and business administrators on existing customer service training program and refresher training courses could be used to ensure staff are competent in their ability to respond to members' inquires and deal with difficult patient/member encounters An evaluation of the existing customer service training program will allow the health plan to identify potential gaps and areas where additional or more frequent training is needed and serve as a guide for implementing changes, if and where necessary. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

UHC CP QI

Results

Table 3-70 presents the 2015 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for UHC CP QI.[3-9,3-10]

Table 3-70—Child Medicaid CAHPS Results *for* UHC CP QI

Measure	2015 Rates	Star Ratings
Global Ratings		
Rating of Health Plan	61.1%	★
Rating of All Health Care	62.9%	★★★
Rating of Personal Doctor	77.0%	★★★★★
Rating of Specialist Seen Most Often	78.7%+	★★★★★+
Composite Measures		
Getting Needed Care	82.8%	★
Getting Care Quickly	84.9%	★
How Well Doctors Communicate	93.0%	★★★
Customer Service	82.1%	★

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

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

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

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

3-9 2015 represents the first year UHC CP QI child members were surveyed; therefore, 2014 rates are not available for the health plan.

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

Conclusions and Recommendations

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

RATING OF HEALTH PLAN

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

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

Promote Quality Improvement Initiatives—The health plan should continue its efforts to implement organization-wide quality improvement initiatives that involve health plan staff members at every level. Methods for achieving this can include aligning quality improvement goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing quality improvement initiatives. Furthermore, progress of quality improvement initiatives should be monitored and reported internally to assess effectiveness of these efforts.

GETTING NEEDED CARE

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

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

services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.

GETTING CARE QUICKLY

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

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

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

CUSTOMER SERVICE

Creating an Effective Customer Service Training Program—Having recently transitioned the customer services it provides to members and providers to an in-house operation, the health plan should ensure the customer service training provided to new staff meets the needs of its unique work environment. The customer service training program should be geared toward teaching the fundamentals of effective communication. By reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff feels competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but to implement a support structure when they are back on the job. Additionally, the health plan should monitor customer service staff to ensure the established policies and procedures for addressing members' and providers' inquiries and requests are being properly adhered to and implemented.

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

Call Centers—An evaluation of current health plan call center hours and practices may be conducted to determine if the hours and resources meet members' needs. If the call center is not meeting members' needs, an after-hours customer service center should be implemented to

assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call may assist in determining if members are getting the help they need and identify potential areas for customer service improvement.

Child Health Insurance Program (CHIP)

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

Results

Table 3-71 presents the 2014 and 2015 question summary rates and global proportions (e.g., the percentage of respondents offering a positive response) and overall 2015 member satisfaction ratings (i.e., star ratings) for each of the global ratings and four composite measures for CHIP.[3-11, 3-12]

Table 3-71—Child Medicaid CAHPS Results *for* CHIP

Measure	2014 Rates	2015 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	70.7%	69.5%	★★★★
Rating of All Health Care	63.6%	65.3%	★★★★
Rating of Personal Doctor	75.0%	75.1%	★★★★★
Rating of Specialist Seen Most Often	62.3%	59.3%+	★+
Composite Measures			
Getting Needed Care	79.4%	81.5%	★
Getting Care Quickly	86.0%	85.6%	★
How Well Doctors Communicate	94.9%	93.8%	★★★
Customer Service	83.9%	84.9%	★

▲ Indicates the 2015 score is significantly higher than the 2014 score.
▼ Indicates the 2015 score is significantly lower than the 2014 score.

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

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

[3-11] NCQA's benchmarks and thresholds for the child Medicaid population were used to derive the overall member satisfaction ratings; therefore, caution should be exercised when interpreting these results.

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

The overall member satisfaction ratings revealed that CHIP scored:

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

A comparison of CHIP's 2014 scores to its corresponding 2015 scores revealed that CHIP did not score significantly higher or lower in 2015 than in 2014 on any of the measures.

Conclusions and Recommendations

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

RATING OF SPECIALIST SEEN MOST OFTEN

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

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

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

CUSTOMER SERVICE

Creating an Effective Customer Service Training Program—The health plans should ensure its customer service training program meets the needs of its unique work environment and members. An evaluation of the existing training program could be conducted to ensure the training topics and frequency of training are meeting the needs of its staff and members. Feedback from employees, managers, and business administrators on existing customer service training program and refresher training courses could be used to ensure staff are competent in their ability to respond to members' inquires and deal with difficult patient/member encounters An evaluation of the existing customer service training program will allow the health plan to identify potential gaps and areas where additional or more frequent training is needed and serve as a guide for implementing changes, if and where necessary. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but to implement a support structure when they are back on the job.

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

GETTING NEEDED CARE

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

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

Referral Process—Health plans should continue efforts to streamline the referral process, where appropriate, to allow health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care.

GETTING CARE QUICKLY

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

for a large percentage of patient no-shows. This analysis could assist the health plans in determining targeted, potential resolutions.

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

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

Provider Survey

The 2015 Hawaii Provider Survey results for participating health plans are presented on the following six domains of satisfaction:

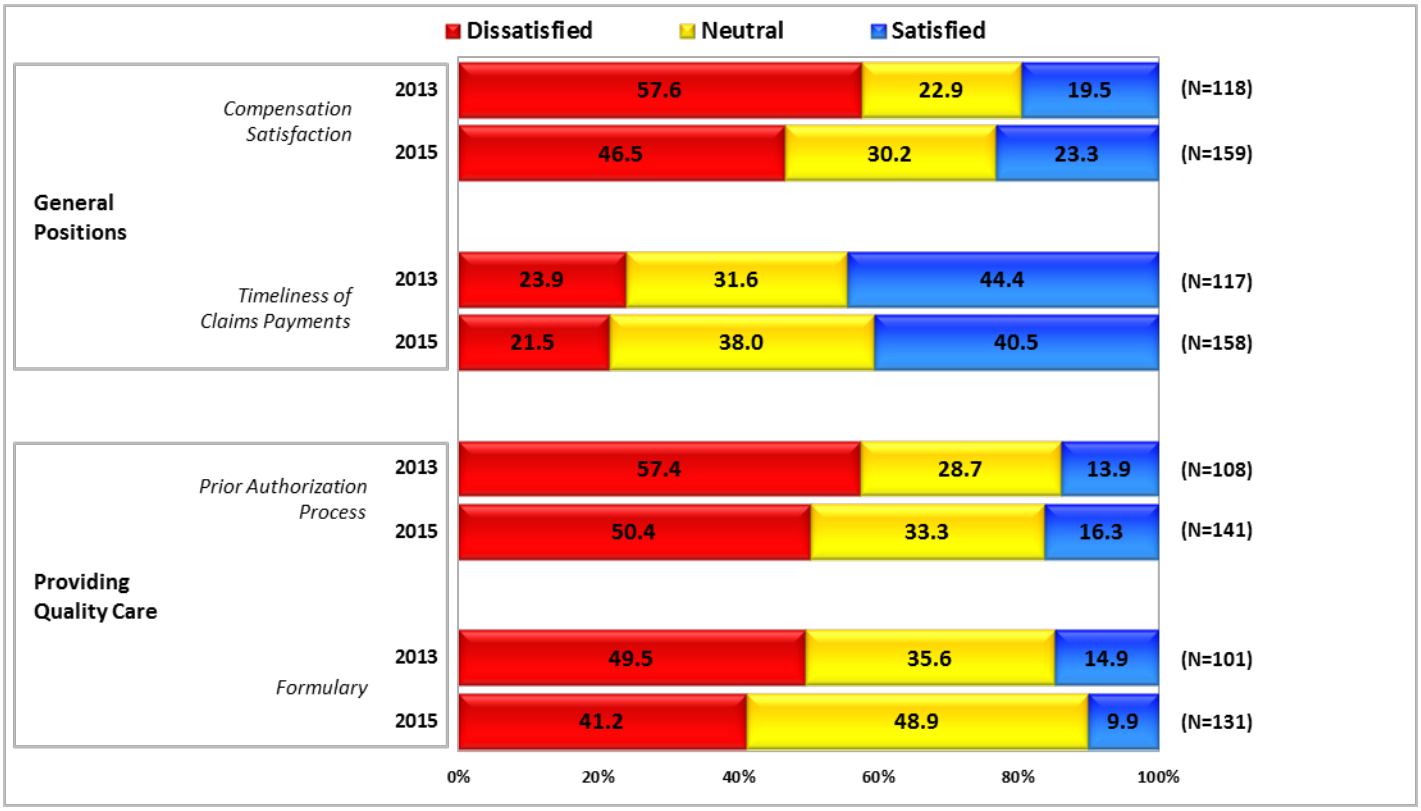
- **General Positions**—presents providers' level of satisfaction with the reimbursement rate (pay schedule) or compensation, and providers' level of satisfaction with the timeliness of claims payments.
- **Providing Quality Care**—presents providers' level of satisfaction with the health plans' prior authorization process and formulary, in terms of having an impact on providers' abilities to deliver quality care.
- **Formulary**—presents providers' level of satisfaction with access to non-formulary drugs.
- **Service Coordinators**—presents providers' level of satisfaction with the helpfulness of service coordinators.
- **Specialists**—presents providers' level of satisfaction with the health plans' number of specialists and number of behavioral health specialists.
- **Behavioral Health**—presents providers' level of satisfaction with the number of licensed behavioral health providers.

AlohaCare QI

Results

Figure 3-1 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions and providing quality care for AlohaCare QI.

Figure 3-1—AlohaCare QI: General Positions and Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

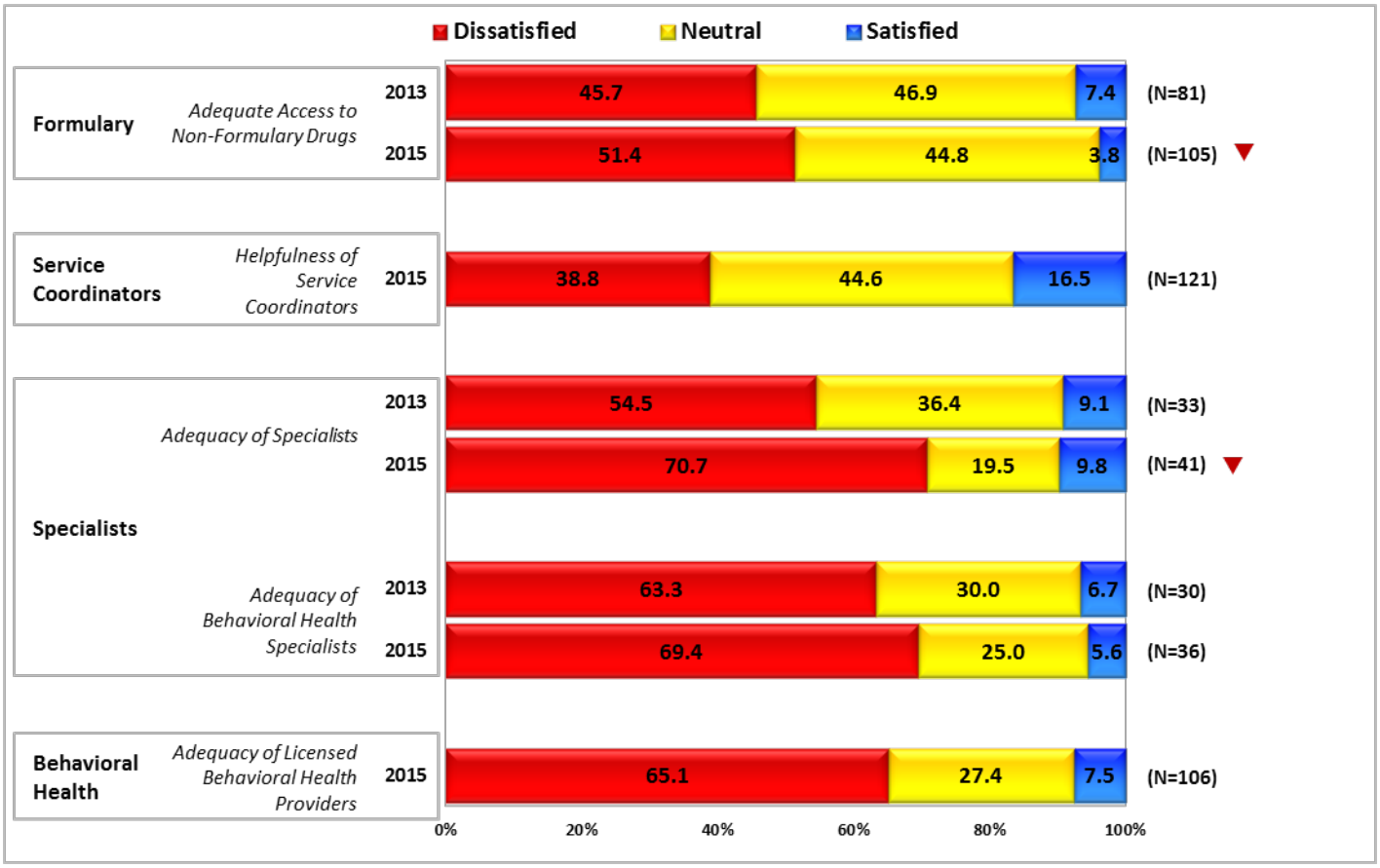
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- AlohaCare QI's 2015 top-box rates for compensation satisfaction and timeliness of claims payments (23.3 percent and 40.5 percent, respectively) were not significantly different than the aggregate of the other health plans.
- AlohaCare QI's 2015 top-box rates for prior authorization process and formulary (16.3 percent and 9.9 percent, respectively) were not significantly different than the aggregate of the other health plans.

A comparison of AlohaCare QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that AlohaCare QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

Figure 3-2 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of formulary, service coordinators, specialists, and behavioral health for AlohaCare QI.[3-13,3-14]

Figure 3-2—AlohaCare QI: Formulary, Service Coordinators, Specialists, and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- AlohaCare QI's 2015 top-box rate for adequate access to non-formulary drugs (3.8 percent) was significantly lower than the aggregate of the other health plans.
- AlohaCare QI's 2015 top-box rate for helpfulness of service coordinators (16.5 percent) was not significantly different than the aggregate of the other health plans.

[3-13] A trend analysis could not be performed for the *Helpfulness of Service Coordinators* measure since this is a new measure included in the 2015 provider survey.

[3-14] A trend analysis could not be performed for the *Adequacy of Licensed Behavioral Health Providers* measure since this is a new measure included in the 2015 provider survey.

AlohaCare QI's 2015 top-box rate for adequacy of specialists (9.8 percent) was significantly lower than the aggregate of the other health plans, and its 2015 top-box rate for adequacy of behavioral health specialists (5.6 percent) was not significantly different than the aggregate of the other health plans.

AlohaCare QI's 2015 top-box rate for adequacy of licensed behavioral health providers (7.5 percent) was not significantly different than the aggregate of the other health plans.

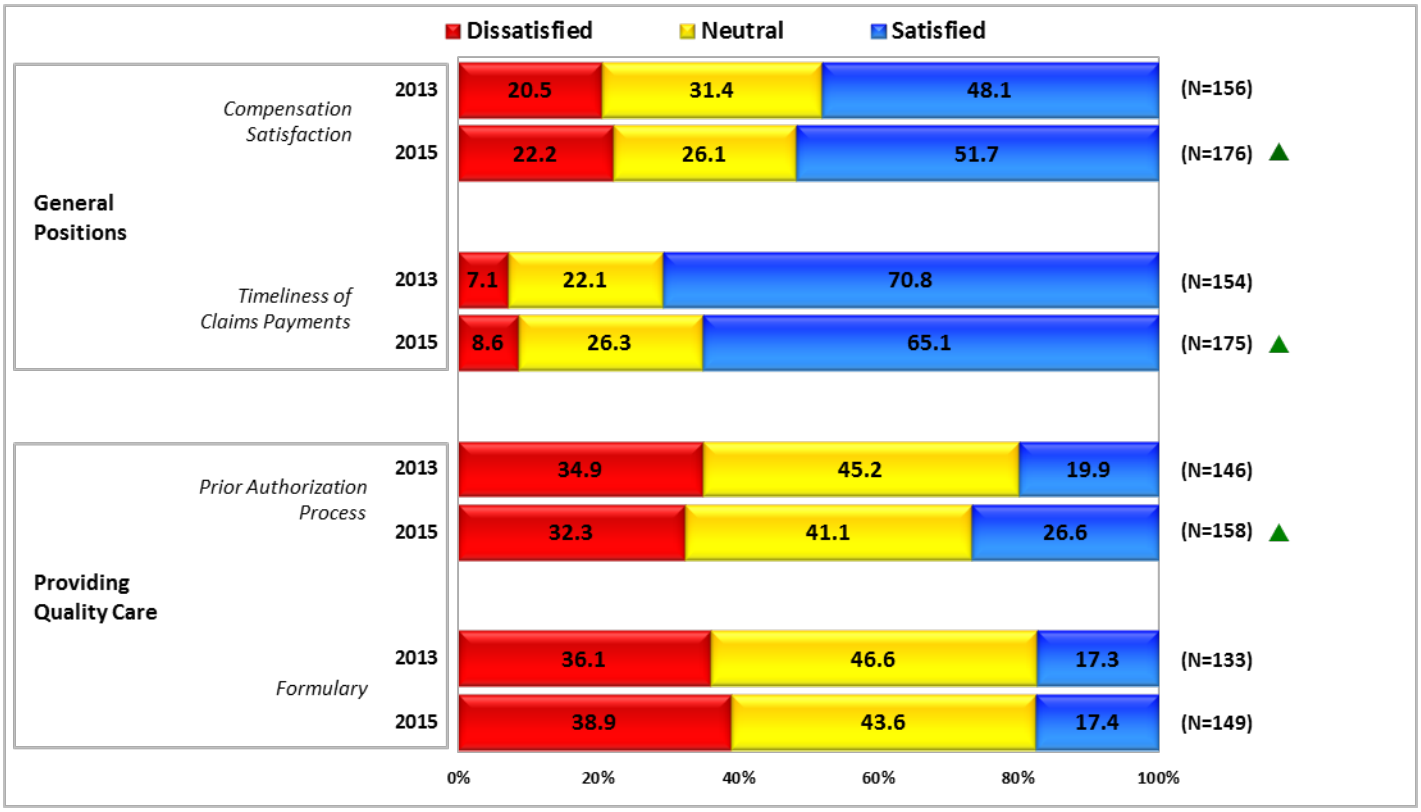
A comparison of AlohaCare QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that AlohaCare QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

HMSA QI

Results

Figure 3-3 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions and providing quality care for HMSA QI.

Figure 3-3—HMSA QI: General Positions and Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

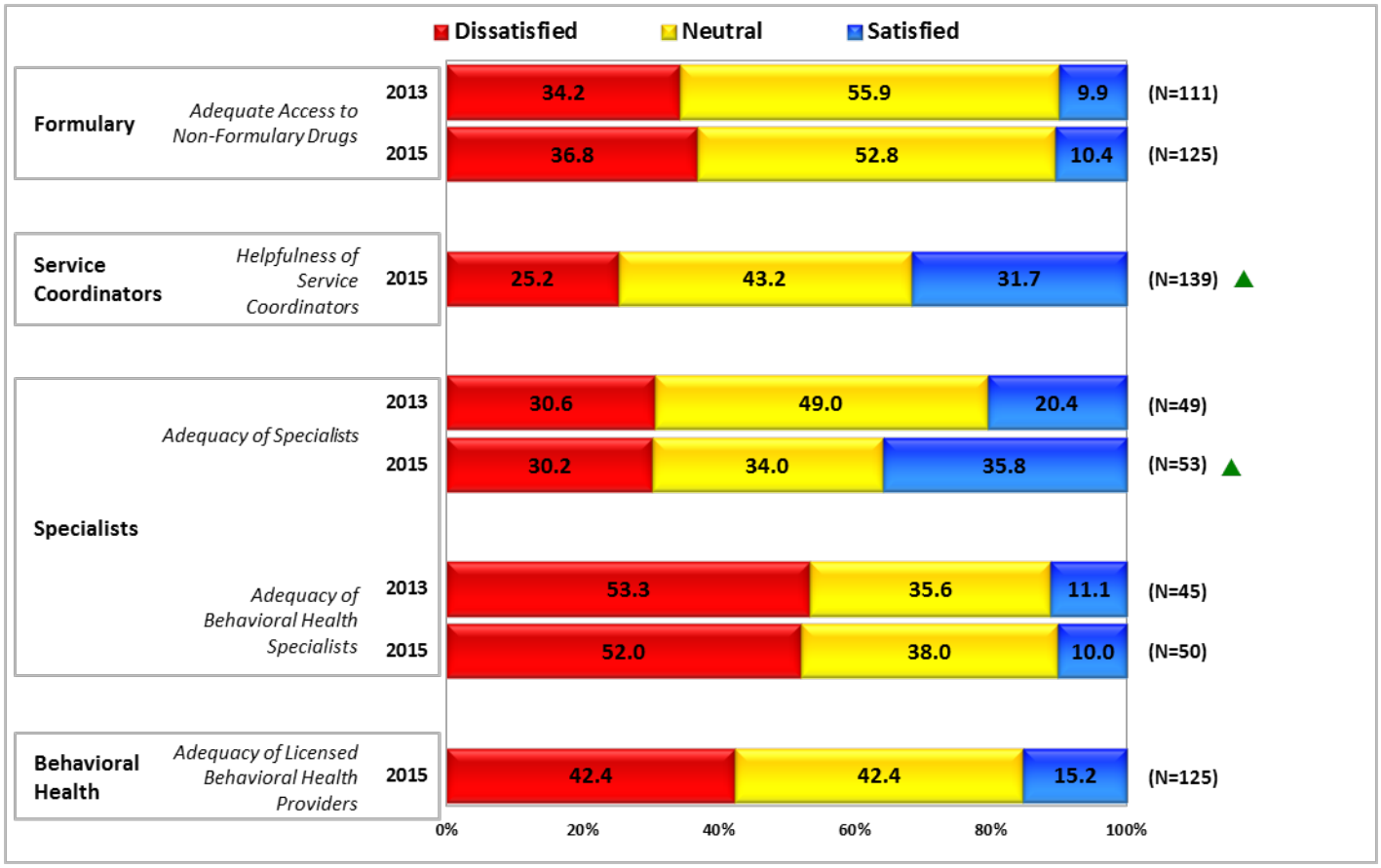
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- HMSA QI's 2015 top-box rate for compensation satisfaction and timeliness of claims payments (51.7 percent and 65.1 percent, respectively) were both significantly higher than the aggregate of the other health plans.
- HMSA QI's 2015 top-box rate for prior authorization process (26.6 percent) was significantly higher than the aggregate of the other health plans, and its 2015 top-box rate for formulary (17.4 percent) was not significantly different than the aggregate of the other health plans.

A comparison of HMSA QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that HMSA QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

Figure 3-4 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of formulary, service coordinators, specialists, and behavioral health for HMSA QI. [3-15,3-16]

Figure 3-4—HMSA QI: Formulary, Service Coordinators, Specialists, and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- HMSA QI's 2015 top-box rate for adequate access to non-formulary drugs (10.4 percent) was not significantly different than the aggregate of the other health plans.
- HMSA QI's 2015 top-box rate for helpfulness of service coordinators (31.7 percent) was significantly higher than the aggregate of the other health plans.
- HMSA QI's 2015 top-box rate for adequacy of specialists (35.8 percent) was significantly higher than the aggregate of the other health plans, and its 2015 top-box rate for adequacy of behavioral health specialists (10.0 percent) was not significantly different than the aggregate of the other health plans.

[3-15] A trend analysis could not be performed for the *Helpfulness of Service Coordinators* measure since this is a new measure included in the 2015 provider survey.

[3-16] A trend analysis could not be performed for the *Adequacy of Licensed Behavioral Health Providers* measure since this is a new measure included in the 2015 provider survey.

- HMSA QI's 2015 top-box rate for adequacy of licensed behavioral health providers (15.2 percent) was not significantly different than the aggregate of the other health plans.

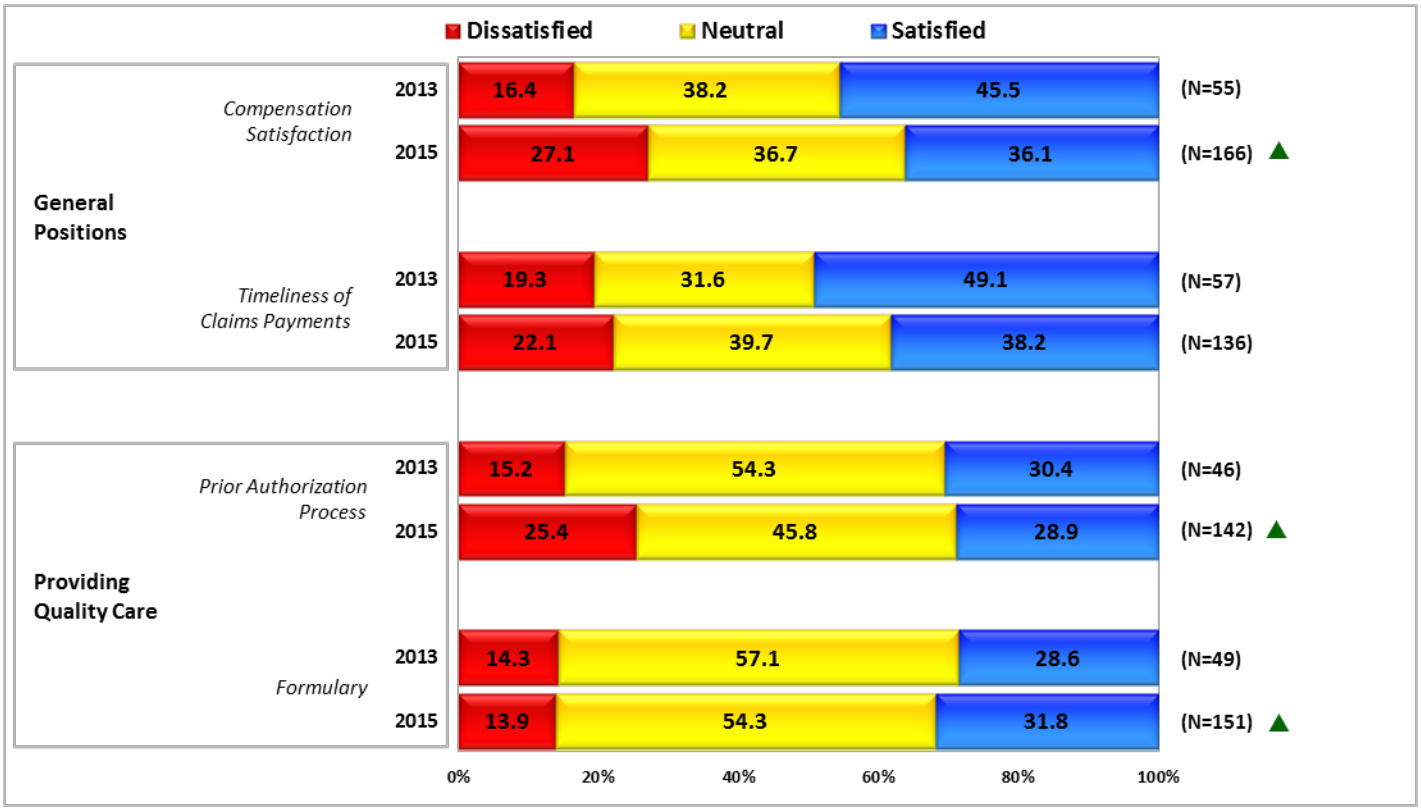
A comparison of HMSA QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that HMSA QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

Kaiser QI

Results

Figure 3-5 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions and providing quality care for Kaiser QI.

Figure 3-5—Kaiser QI: General Positions and Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

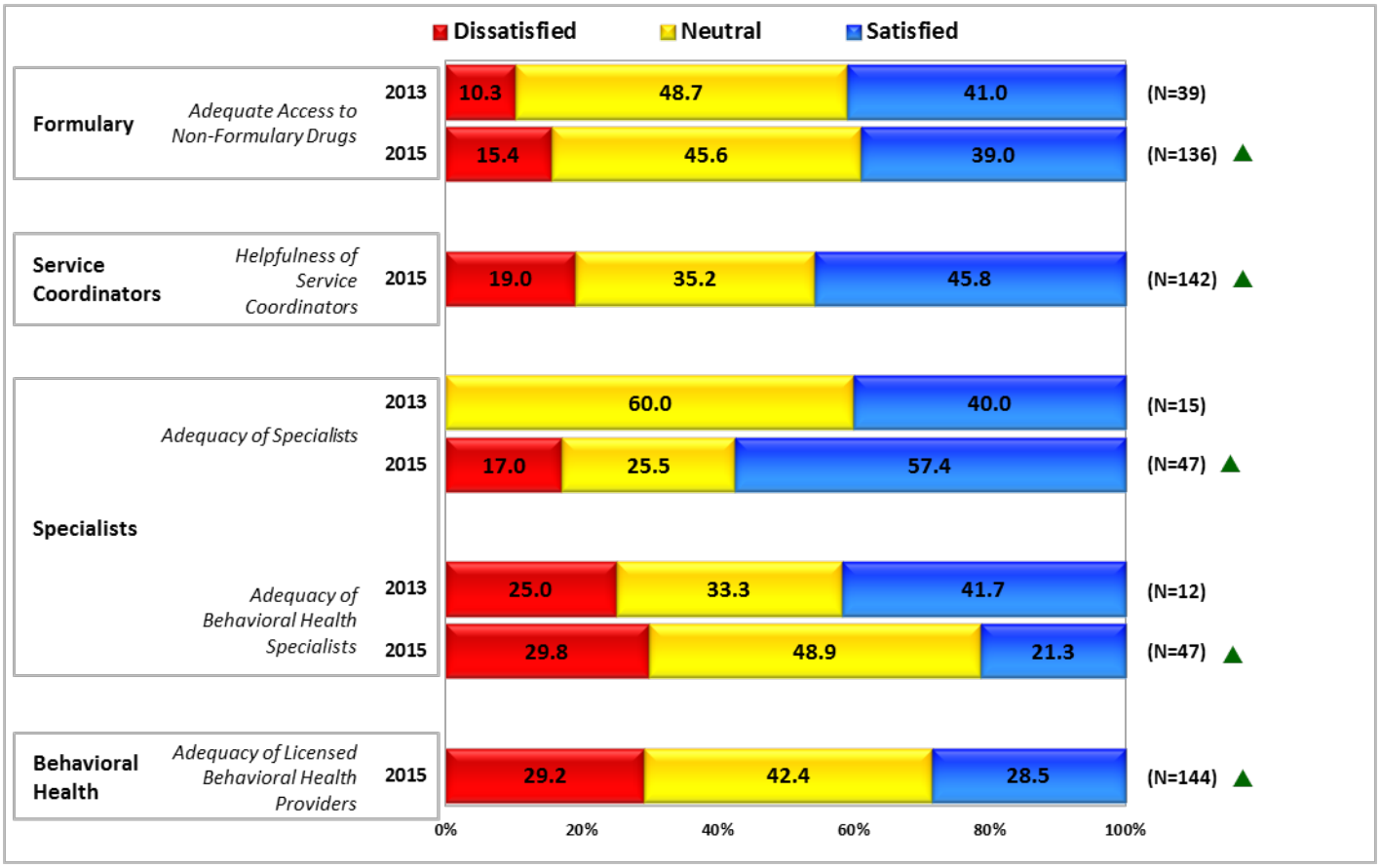
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- Kaiser QI's 2015 top-box rate for compensation satisfaction (36.1 percent) was significantly higher than the aggregate of the other health plans, and its 2015 top-box rate for timeliness of claims payments (38.2 percent) was not significantly different than the aggregate of the other health plans.
- Kaiser QI's 2015 top-box rates for prior authorization process and formulary (28.9 percent and 31.8 percent, respectively) were significantly higher than the aggregate of the other health plans.

A comparison of Kaiser QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that Kaiser QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

Figure 3-6 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of formulary, service coordinators, specialists, and behavioral health for Kaiser QI.[3-17,3-18]

Figure 3-6—Kaiser QI: Formulary, Service Coordinators, Specialists, and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- Kaiser QI's 2015 top-box rate for adequate access to non-formulary drugs (39.0 percent) was significantly higher than the aggregate of the other health plans.
- Kaiser QI's 2015 top-box rate for helpfulness of service coordinators (45.8 percent) was significantly higher than the aggregate of the other health plans.
- Kaiser QI's 2015 top-box rates for adequacy of specialists and adequacy of behavioral health specialists (57.4 percent and 21.3 percent, respectively) were significantly higher than the aggregate of the other health plans.
- Kaiser QI's 2015 top-box rate for adequacy of licensed behavioral health providers (28.5 percent) was significantly higher than the aggregate of the other health plans.

[3-17] A trend analysis could not be performed for the *Helpfulness of Service Coordinators* measure since this is a new measure included in the 2015 provider survey.

[3-18] A trend analysis could not be performed for the *Adequacy of Licensed Behavioral Health Providers* measure since this is a new measure included in the 2015 provider survey.

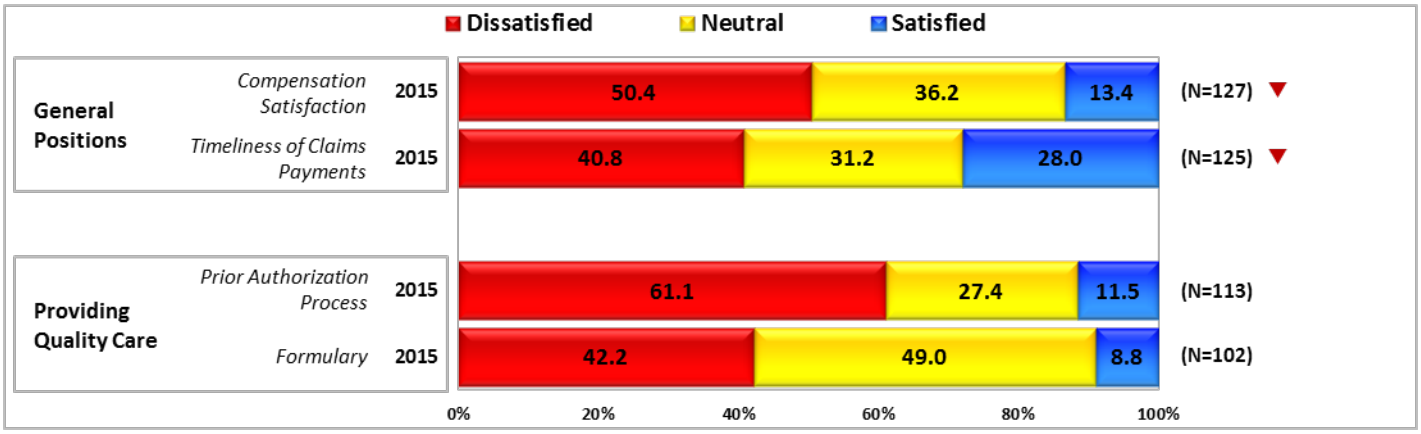
A comparison of Kaiser QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that Kaiser QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

‘Ohana CCS

Results

Figure 3-7 depicts the 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions and providing quality care for ‘Ohana CCS.[3-19]

Figure 3-7—‘Ohana CCS: General Positions and Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan’s top-box rate is significantly higher than the aggregate of the other health plans.*

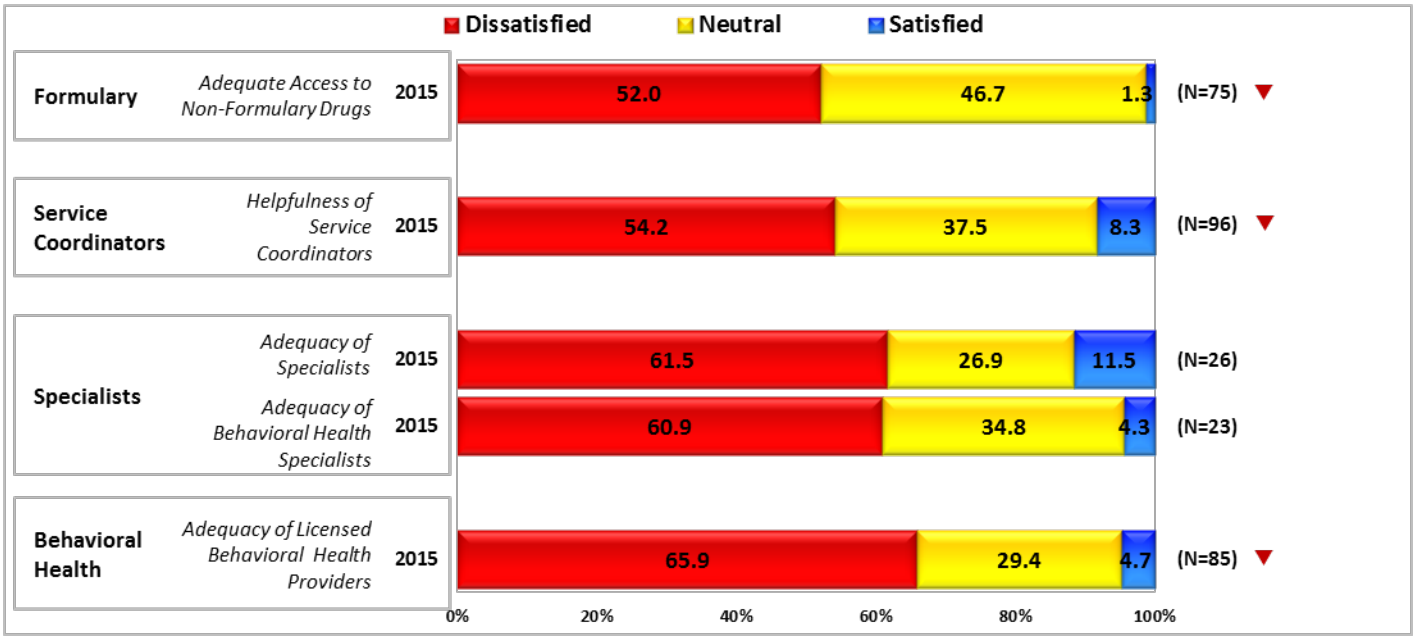
▼ *indicates the health plan’s top-box rate is significantly lower than the aggregate of the other health plans.*

- ‘Ohana CCS’ 2015 top-box rate for compensation satisfaction and timeliness of claims payments (13.4 percent and 28.0 percent, respectively) were significantly lower than the aggregate of the other health plans.
- ‘Ohana CCS’ 2015 top-box rates for prior authorization process and formulary (11.5 percent and 8.8 percent, respectively) were not significantly different than the aggregate of the other health plans.

[3-19] A trend analysis could not be performed for ‘Ohana CCS since this is the first year that this health plan is being surveyed.

Figure 3-8 depicts the 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of formulary, service coordinators, specialists, and behavioral health for 'Ohana CCS.[3-20]

Figure 3-8—'Ohana CCS: Formulary, Service Coordinators, Specialists, and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- 'Ohana CCS' 2015 top-box rate for adequate access to non-formulary drugs (1.3 percent) was significantly lower than the aggregate of the other health plans.
- 'Ohana CCS' 2015 top-box rate for helpfulness of service coordinators (8.3 percent) was significantly lower than the aggregate of the other health plans.
- 'Ohana CCS' 2015 top-box rates for adequacy of specialists and adequacy of behavioral health specialists (11.5 percent and 4.3 percent, respectively) were not significantly different than the aggregate of the other health plans.
- 'Ohana CCS' 2015 top-box rate for adequacy of licensed behavioral health providers (4.7 percent) was significantly lower than the aggregate of the other health plans.

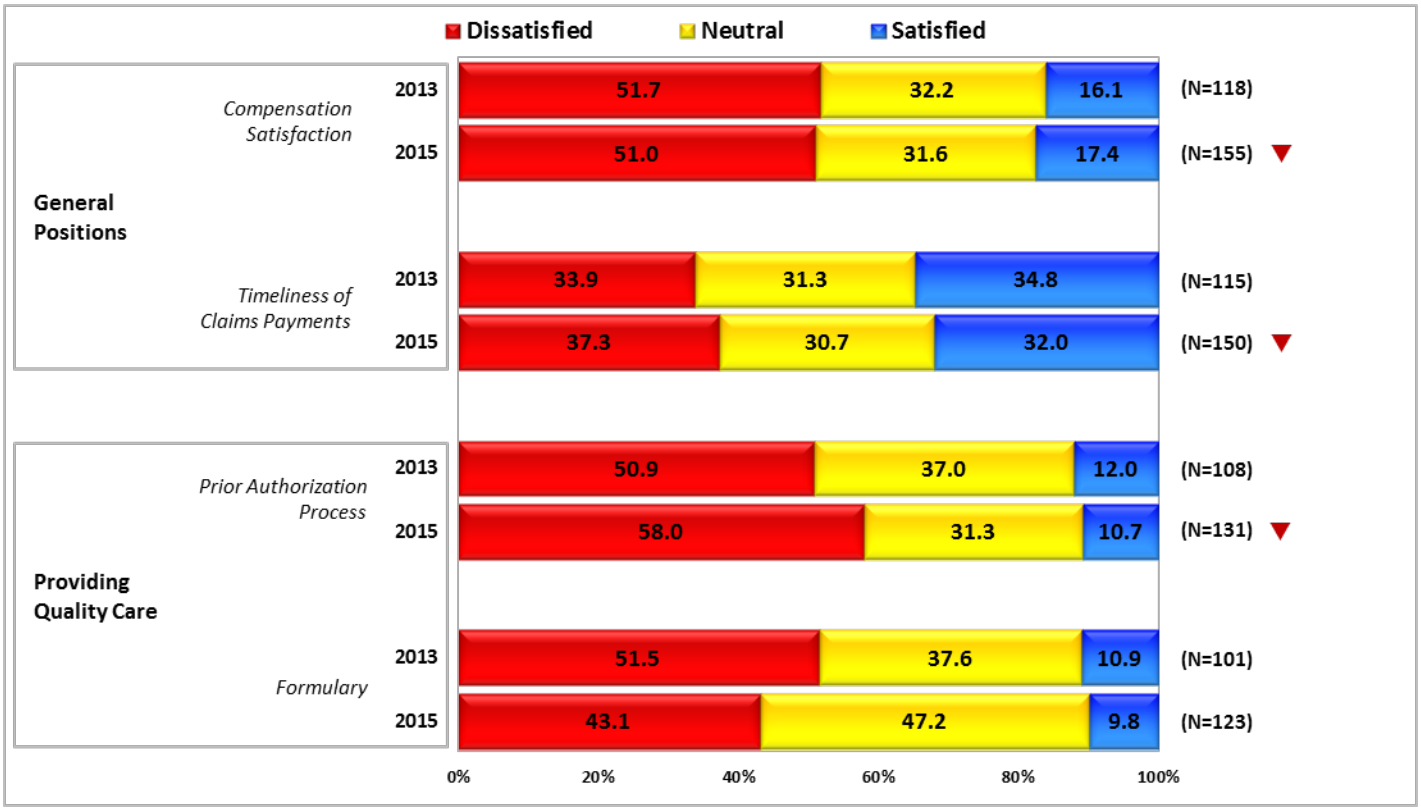
[3-20] Trend analysis could not be performed for 'Ohana CCS since this is the first year that this health plan was included in the survey.

'Ohana QI

Results

Figure 3-9 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions and providing quality care for 'Ohana QI.

Figure 3-9—'Ohana QI: General Positions and Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

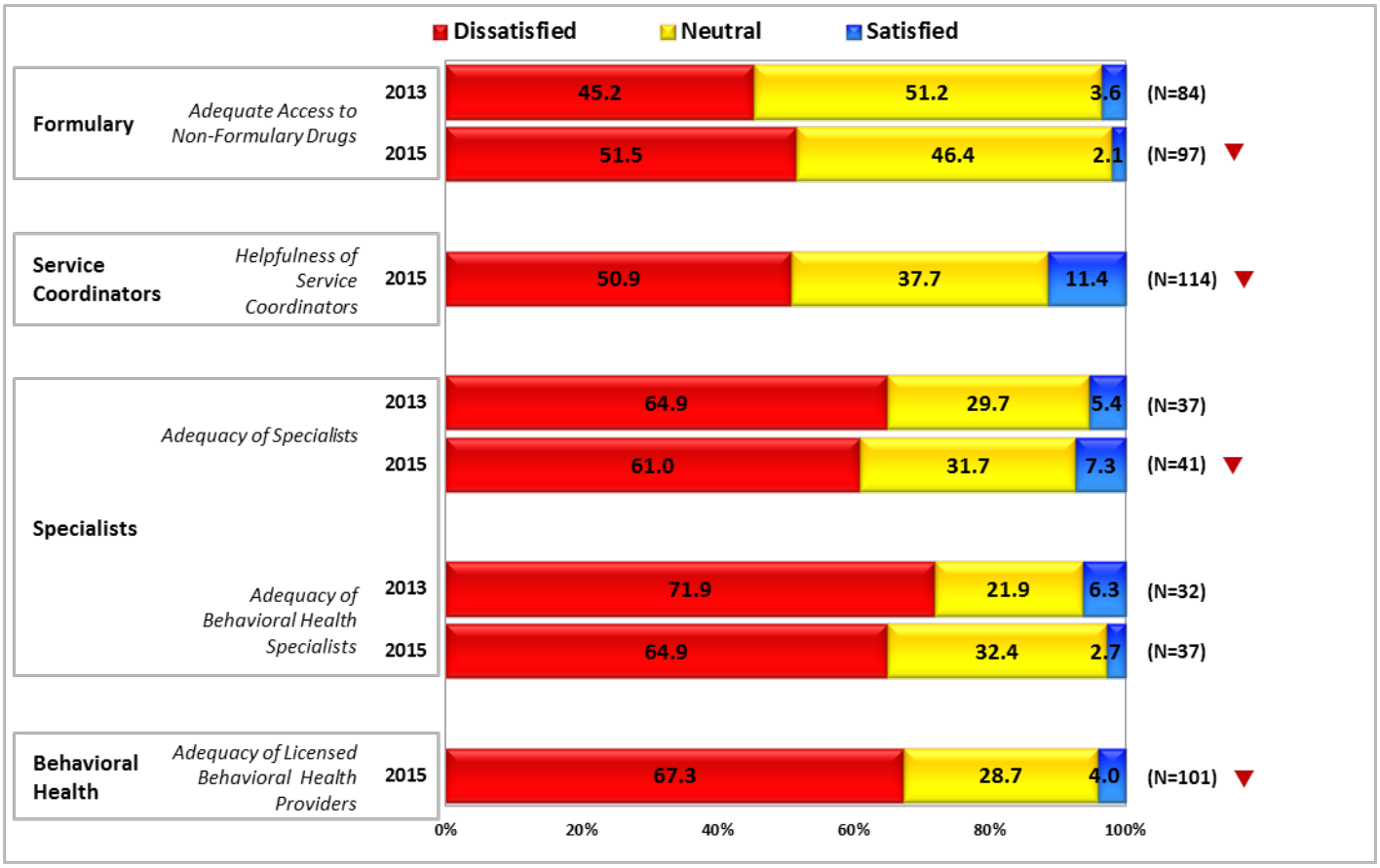
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- 'Ohana QI's 2015 top-box rate for compensation satisfaction and timeliness of claims payments (17.4 percent and 32.0 percent, respectively) were significantly lower than the aggregate of the other health plans.
- 'Ohana QI's 2015 top-box rate for prior authorization process (10.7 percent) was significantly lower than the aggregate of the other health plans, and its 2015 top-box rate for formulary (9.8 percent) was not significantly different than the aggregate of the other health plans.

A comparison of 'Ohana QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that 'Ohana QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

Figure 3-10 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of formulary, service coordinators, specialists, and behavioral health for ‘Ohana QI.[3-21,3-22]

Figure 3-10—‘Ohana QI: Formulary, Service Coordinators, Specialists, and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan’s top-box rate is significantly higher than the aggregate of the other health plans.*

▼ *indicates the health plan’s top-box rate is significantly lower than the aggregate of the other health plans.*

- ‘Ohana QI’s 2015 top-box rate for adequate access to non-formulary drugs (2.1 percent) was significantly lower than the aggregate of the other health plans.
- ‘Ohana QI’s 2015 top-box rate for helpfulness of service coordinators (11.4 percent) was significantly lower than the aggregate of the other health plans.
- ‘Ohana QI’s 2015 top-box rate for adequacy of specialists (7.3 percent) was significantly lower than the aggregate of the other health plans, and the 2015 top-box rate for adequacy of behavioral health specialists (2.7 percent) was not significantly different than the aggregate of the other health plans.

[3-21] A trend analysis could not be performed for the *Helpfulness of Service Coordinators* measure since this is a new measure included in the 2015 provider survey.

[3-22] A trend analysis could not be performed for the *Adequacy of Licensed Behavioral Health Providers* measure since this is a new measure included in the 2015 provider survey.

- ‘Ohana QI’s 2015 top-box rate for adequacy of licensed behavioral health providers (4.0 percent) was significantly lower than the aggregate of the other health plans.

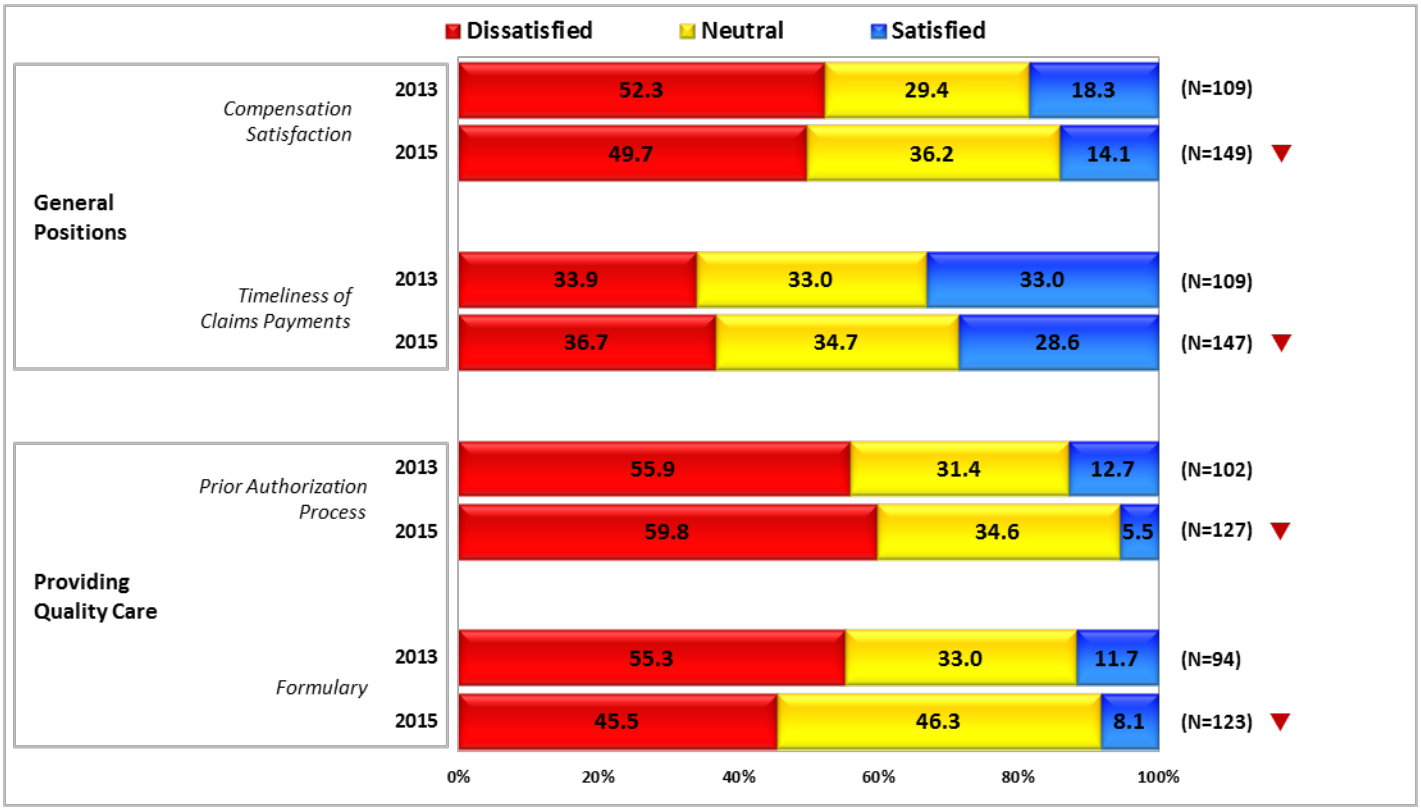
A comparison of ‘Ohana QI’s 2013 top-box scores to its corresponding 2015 top-box scores revealed that ‘Ohana QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

UHC CP QI

Results

Figure 3-11 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of general positions and providing quality care for UHC CP QI.

Figure 3-11—UHC CP QI: General Positions and Providing Quality Care



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

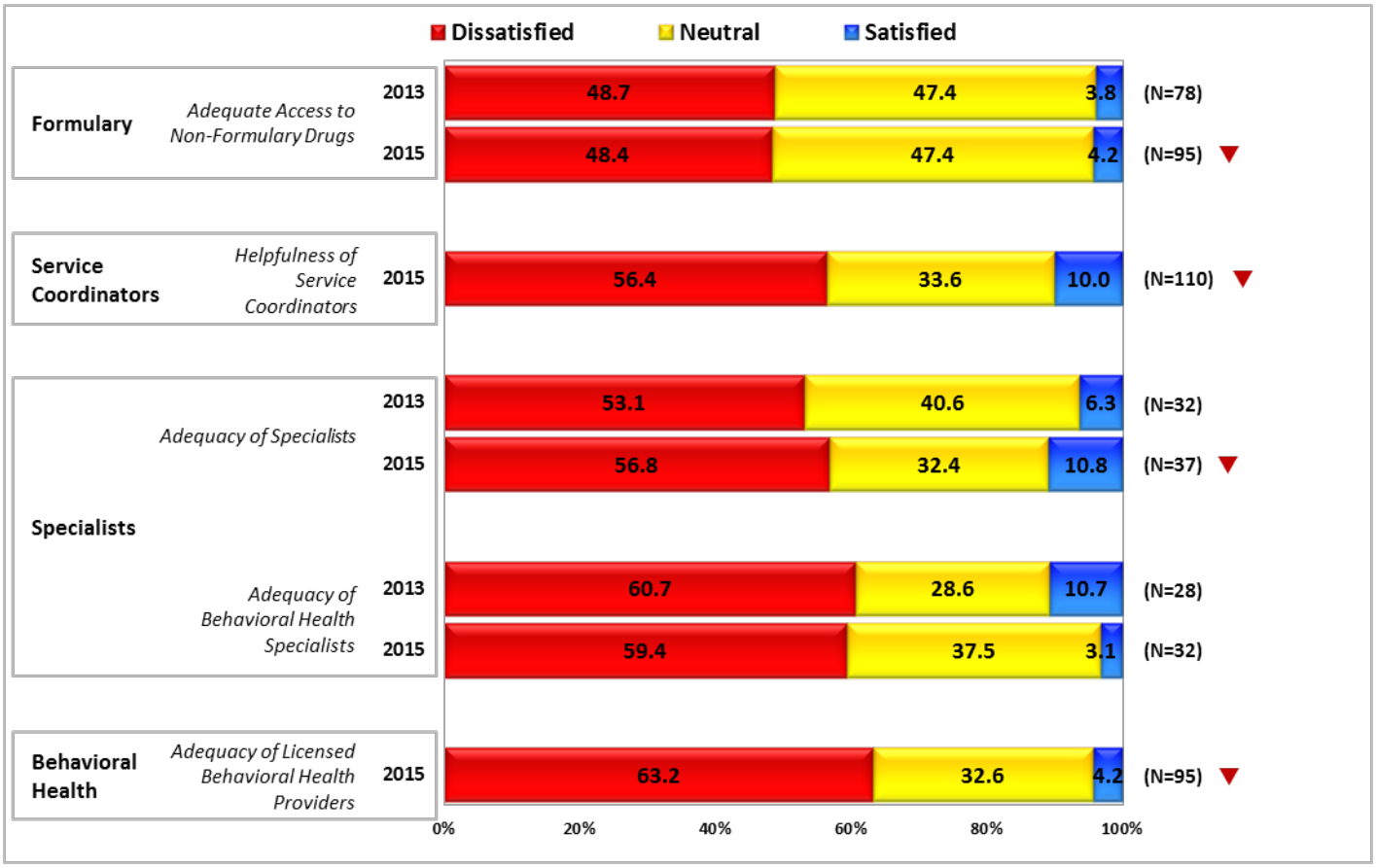
▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- UHC CP QI's 2015 top-box rate for compensation satisfaction and timeliness of claims payments (14.1 percent and 28.6 percent, respectively) were significantly lower than the aggregate of the other health plans.
- UHC CP QI's 2015 top-box rates for prior authorization process and formulary (5.5 percent and 8.1 percent, respectively) were significantly lower than the aggregate of the other health plans.

A comparison of UHC CP QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that UHC CP QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

Figure 3-12 depicts the 2013 and 2015 response category proportions (e.g., the percentage of responses that fell into the categories of satisfied, neutral, and dissatisfied) on the domains of formulary, service coordinators, specialists, and behavioral health for UHC CP QI.[3-23,3-24]

Figure 3-12—UHC CP QI: Formulary, Service Coordinators, Specialists, and Behavioral Health



Note: Percentages may not total 100.0% due to rounding.

▲ *indicates the health plan's top-box rate is significantly higher than the aggregate of the other health plans.*

▼ *indicates the health plan's top-box rate is significantly lower than the aggregate of the other health plans.*

- UHC CP QI's 2015 top-box rate for adequate access to non-formulary drugs (4.2 percent) was significantly lower than the aggregate of the other health plans.
- UHC CP QI's 2015 top-box rate for helpfulness of service coordinators (10.0 percent) was significantly lower than the aggregate of the other health plans.
- UHC CP QI's 2015 top-box rate for adequacy of specialists (10.8 percent) was significantly lower than the aggregate of the other health plans, and its 2015 top-box rate for adequacy of behavioral health specialists (3.1 percent) was not significantly different than the aggregate of the other health plans.

[3-23] A trend analysis could not be performed for the *Helpfulness of Service Coordinators* measure since this is a new measure included in the 2015 provider survey.

[3-24] A trend analysis could not be performed for the *Adequacy of Licensed Behavioral Health Providers* measure since this is a new measure included in the 2015 provider survey.

- UHC CP QI's 2015 top-box rate for adequacy of licensed behavioral health providers (4.2 percent) was significantly lower than the aggregate of the other health plans.

A comparison of UHC CP QI's 2013 top-box scores to its corresponding 2015 top-box scores revealed that UHC CP QI did not score significantly higher or lower in 2015 than in 2013 on any of these measures.

Introduction

This section compares EQR activity results across the Hawaii health plans and provides comparisons to statewide scores or to national benchmarks, if available and methodologically appropriate to do so.

Health Plan Comparison

Compliance Monitoring Review

As described in Appendix A–Methodology for Conducting EQR Activities, CCS was the only plan that had an on-site compliance review in 2015, in order to bring the plan into the same three-year review cycle as the QI plans. Table 4-1 illustrates the compliance review results for CCS as compared to the results from a similar review of standards conducted for the health plans in 2013.

Table 4-1—Compliance Standards and Scores

Standard #	Standard Name	2015 'Ohana 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%**

CCS' overall score of 95 percent exceeded the statewide score for a similar review of the health plans in 2013 (93 percent). The QI plans and CCS have subsequently addressed all required corrective actions resulting from the reviews conducted within the past three years and have demonstrated compliance with all requirements reviewed.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audits—QI Health Plans

Table 4-2 compares each QI health plan's compliance with each IS standard reviewed in an NCQA HEDIS Compliance Audit. Regardless of the specific populations for which the QI health plans were contracted during measurement year 2014 (i.e., non-ABD, ABD, or CCS), each individual health plan used the same data systems and processes to capture, store, and manage its own data required for performance measure reporting. Therefore, the health plan's compliance with each IS standard was assessed at the health plan level, not at the population level.

As demonstrated below, all health plans but one were *Fully Compliant* with the IS standards applicable to the measures under the scope of the audit. The health plans were not required to report any HEDIS call center measures; therefore, IS 6.0 was *Not Applicable*.

AlohaCare was *Substantially Compliant* with IS 5.0 (Supplemental Data—Capture, Transfer, and Entry). HSAG found that one of AlohaCare's nonstandard supplemental data sources did not capture all the required data elements for reporting. As such, this data source was not approved by the auditors for reporting. Nonetheless, since AlohaCare could still use the medical record abstracted data to report its measures, the impact of not having this data source approved was mitigated.

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

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

NON-ABD HEDIS PERFORMANCE MEASURE RESULTS

CHILDREN'S PREVENTIVE CARE

Table 4-3 displays, by health plan, the Children's Preventive Care performance measure results for the non-ABD populations, compared to the national Medicaid percentiles. For the *Well Child Visits in the First 15 Months of Life—Zero Visits* indicator, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied. All health plans reported valid rates for all 29 indicators within this domain. For Kaiser, 19 of the 29 reported rates ranked above the HEDIS 2014 national Medicaid 90th percentile, and no rates fell below the 25th percentile. The only other plan to report a Children's Preventive Care measure rate that ranked above the 90th percentile was HMSA (*Well-Child Visits in the First 15 Months of Life—Six or More Visits*). AlohaCare, HMSA, 'Ohana, and UHC CP reported 18, 19, 22, and 21 indicators, respectively, that ranked below the 25th percentile.

Table 4-3—Comparison of HEDIS 2015 Non-ABD Rates Under Children's Preventive Care

	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	47.45%	47.69%	45.08%	**32.12%**	**27.98%**
Childhood Immunization Status					
DTaP	**64.23%**	**70.07%**	**89.91%**	**53.80%**	**65.71%**
IPV	**79.56%**	**82.00%**	93.80%	**62.66%**	**74.29%**
MMR	**79.56%**	90.51%	93.20%	**67.72%**	**75.00%**
HiB	**79.32%**	**87.59%**	93.32%	**65.19%**	**77.14%**
Hepatitis B	**80.54%**	**68.86%**	94.29%	**63.29%**	**72.14%**
VZV	**79.56%**	89.05%	92.71%	**65.82%**	**77.14%**
Pneumococcal Conjugate	**65.69%**	**72.02%**	**89.19%**	**51.27%**	**60.71%**
Hepatitis A	**71.53%**	**65.69%**	**92.59%**	**66.46%**	**72.14%**
Rotavirus	**55.23%**	**58.64%**	**87.24%**	**39.24%**	**52.14%**
Influenza	56.69%	40.88%	**83.48%**	44.30%	49.29%
Combination #2	**60.83%**	**55.96%**	**88.58%**	**49.37%**	**55.71%**
Combination #3	**58.39%**	**52.55%**	**87.85%**	**44.30%**	**52.86%**
Combination #4	**56.20%**	**46.96%**	**87.61%**	**41.77%**	**50.71%**
Combination #5	**42.58%**	**42.09%**	**83.11%**	**33.54%**	**39.29%**
Combination #6	45.50%	**32.12%**	**80.32%**	34.18%	38.57%
Combination #7	**41.36%**	**39.66%**	**82.87%**	**31.01%**	**37.86%**
Combination #8	44.04%	**30.41%**	**80.19%**	33.54%	37.14%
Combination #9	32.60%	28.22%	**76.18%**	**25.32%**	31.43%
Combination #10	31.87%	27.01%	**76.06%**	**24.68%**	30.00%
Immunization for Adolescents					
Meningococcal	**57.42%**	**48.91%**	86.30%	**48.68%**	**25.30%**
Tdap/Td	**66.42%**	**54.50%**	84.19%	**51.32%**	**30.12%**
Combined	**55.23%**	**45.99%**	80.87%	**43.42%**	**22.89%**

Table 4-3—Comparison of HEDIS 2015 Non-ABD Rates Under Children's Preventive Care					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation	61.07%	63.26%	**93.92%**	67.40%	64.72%
Counseling for Nutrition	54.01%	**38.93%**	**98.05%**	50.61%	56.20%
Counseling for Physical Activity	52.07%	**35.77%**	**98.05%**	45.99%	43.31%
Well-Child Visits in the First 15 Months of Life					
0 Visits[1]	1.70%	1.72%	0.28%	**3.65%**	**5.00%**
6 or More Visits	57.91%	**77.30%**	**90.38%**	59.85%	**54.55%**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	**64.72%**	79.02%	**87.08%**	**62.29%**	**57.66%**

[1]*A lower rate indicates better performance for this measure.*

Note: Kaiser received approval from the MQD to report nine measures via the Administrative methodology. These measures were CIS, CCS, COL, CDC, HPV, FPC, IMA, W15, and W34.

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

WOMEN'S HEALTH

Table 4-4 displays the Women's Health performance measure results for the non-ABD populations, compared to the national Medicaid percentiles. All health plans reported valid rates for all six Women's Health indicators. Kaiser reported rates that were above the 90th percentile for all six indicators. All rates reported by HMSA were above the HEDIS 2014 Medicaid 25th percentile. AlohaCare and UHC CP reported four indicators below the 25th percentile, while 'Ohana reported two.

Table 4-4—Comparison of HEDIS 2015 Non-ABD Rates Under Women's Health					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Breast Cancer Screening					
Breast Cancer Screening	53.52%	67.14%	**81.41%**	51.96%	**47.14%**
Cervical Cancer Screening					
Cervical Cancer Screening	62.53%	66.39%	**81.00%**	**47.20%**	**42.09%**
Chlamydia Screening in Women					
16–20 Years	**42.17%**	59.00%	**71.52%**	46.46%	48.48%
21–24 Years	**47.39%**	63.30%	**73.02%**	56.64%	**51.18%**
Total	**44.79%**	61.11%	**72.20%**	53.26%	50.42%

Table 4-4—Comparison of HEDIS 2015 Non-ABD Rates Under Women's Health					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Human Papillomavirus Vaccine for Female Adolescents					
Human Papillomavirus Vaccine for Female Adolescents	**10.71%**	17.03%	**35.06%**	**13.16%**	**4.65%**

Note: Kaiser received approval from the MQD to report nine measures via the Administrative methodology. These measures were CIS, CCS, COL, CDC, HPV, FPC, IMA, W15, and W34.

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

CARE FOR CHRONIC CONDITIONS

Table 4-5 displays the Care for Chronic Conditions performance measure results for the non-ABD populations, compared to the national Medicaid percentiles. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* indicator, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied. All health plans reported valid rates for the eight Care for Chronic Conditions indicators. For Kaiser, five of the eight reported rates ranked above the HEDIS 2014 Medicaid 90th percentile, while none of the rates fell below the 25th percentile. Both AlohaCare and UHC CP's reported rates fell below the 25th percentile for four of the eight indicators in this domain. HMSA reported three rates that were below the 25th percentile, and 'Ohana had one reported rate that was below the 25th percentile.

Table 4-5—Comparison of HEDIS 2015 Non-ABD Rates Under Care for Chronic Conditions					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Comprehensive Diabetes Care					
HbA1c Testing	84.52%	81.75%	**97.01%**	83.70%	81.00%
HbA1c Poor Control (>9.0%)[1]	**55.74%**	48.91%	30.82%	52.31%	**59.05%**
HbA1c Control (<8.0%)	**35.34%**	41.24%	55.14%	39.90%	**33.26%**
HbA1c Control (<7.0%)	**21.70%**	**27.05%**	30.24%	**21.17%**	**19.88%**
Eye Exam	55.74%	57.85%	**74.82%**	51.09%	62.90%
Nephropathy	79.05%	81.57%	**93.76%**	81.02%	81.45%
Blood Pressure Control (<140/90)	60.29%	**50.36%**	**85.57%**	63.02%	**50.68%**
Controlling High Blood Pressure					
Controlling High Blood Pressure	**45.26%**	**39.66%**	**80.78%**	52.80%	50.12%

[1] *A lower rate indicates better performance for this measure.*

Note: Kaiser received approval from the MQD to report nine measures via the Administrative methodology. These measures were CIS, CCS, COL, CDC, HPV, FPC, IMA, W15, and W34. For CDC, Kaiser was required to report the Eye Exam indictor using the Hybrid methodology.

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

ACCESS TO CARE

Table 4-6 displays the Access to Care performance measure results for the non-ABD populations, compared to the national Medicaid percentiles. All health plans reported valid rates for 11 of the 12 indicators under Access to Care. None of the plans reported a valid rate for the *Adults' Access to Preventive/Ambulatory Health Services—65+ years* rate due to having fewer than 30 members in the denominator; therefore, results are denoted as *NA*. For Kaiser, two of the 11 reported rates ranked above the HEDIS 2014 Medicaid 90th percentile, and one reported rate fell below the 25th percentile. AlohaCare, 'Ohana, and UHC CP reported 9, 8, and 10 rates, respectively, that fell below the 25th percentile. HMSA reported four rates that fell below the 25th percentile.

Table 4-6—Comparison of HEDIS 2015 Non-ABD Rates Under Access to Care

	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Adults' Access to Preventive/Ambulatory Health Services					
20-44 years	**70.48%**	**78.08%**	83.48%	**61.84%**	**61.64%**
45-64 years	**79.17%**	**85.79%**	87.59%	**76.62%**	**75.93%**
65+ years	NA	NA	NA	NA	NA
Total	**73.41%**	80.70%	84.93%	**67.59%**	**67.05%**
Children and Adolescents' Access to Primary Care Practitioners					
12–24 months	**95.80%**	97.55%	**99.63%**	**92.73%**	**90.84%**
25 months–6 years	**85.42%**	92.70%	93.23%	**80.86%**	**77.33%**
7–11 years	87.95%	93.20%	93.74%	**85.65%**	**86.05%**
12–19 years	**84.18%**	91.47%	92.29%	**77.45%**	**78.71%**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					
Initiation of AOD Treatment	**33.24%**	37.30%	**25.61%**	38.07%	**31.97%**
Engagement of AOD Treatment	7.84%	17.08%	18.78%	15.40%	7.86%
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	**67.64%**	**67.64%**	91.73%	**75.88%**	**62.61%**
Postpartum Care	**51.82%**	**46.96%**	**77.13%**	58.81%	**49.58%**

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

UTILIZATION

Table 4-7 displays the Utilization performance measure results for the non-ABD populations, compared to the national Medicaid percentiles. For the *Ambulatory Care—ED Visits/1,000* and *Frequency of Ongoing Prenatal Care—<21 Percent* indicators, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied. The *Enrollment by Product Line*, *Inpatient Utilization—General Hospital/Acute Care*, and *Mental Health Utilization* measures are presented for informational purposes only, so no comparisons to HEDIS 2014 percentiles were performed. Further, Medicaid national percentiles do not exist for *Plan All-Cause Readmission*, so comparisons to percentiles were not performed.

All health plans reported valid rates for all 25 of the indicators under this domain. Of the four rates for which comparisons to national percentiles were conducted, Kaiser reported two that ranked above the HEDIS 2014 Medicaid 90th percentile, and one fell below the 25th percentile. UHC CP reported three rates that fell below the 25th percentile, AlohaCare and HMSA both reported two rates that fell below the 25th percentile, and 'Ohana reported one rate that fell below the 25th percentile.

Table 4-7—Comparison of HEDIS 2015 Non-ABD Rates Under Utilization					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Ambulatory Care					
ED Visits/1,000[3]	48.26	41.00	**23.89**	57.25	53.34
Outpatient Visits/1,000	**272.78**	330.28	**284.95**	**302.29**	**255.45**
Enrollment by Product Line[1]					
0–19 years	0.54	0.56	0.64	0.29	0.28
20–44 years	0.31	0.30	0.24	0.46	0.47
45–64 years	0.14	0.14	0.12	0.25	0.25
65+ years	0.00	0.00	0.00	0.00	0.00
Frequency of Ongoing Prenatal Care					
<21 Percent[3]	15.09%	**21.41%**	**0.23%**	13.82%	**23.80%**
81+ Percent	**36.50%**	**27.74%**	67.43%	48.51%	**27.48%**
Inpatient Utilization-General Hospital/Acute Care[4]					
Total Inpatient Discharges/1,000	6.44	5.34	3.61	9.76	7.93
Total Inpatient Days/1,000	28.24	21.36	13.56	49.38	43.49
Total Inpatient Average Length of Stay	4.38	4.00	3.75	5.06	5.48
Total Medicine Discharges/1,000	2.74	2.14	1.46	4.89	3.37
Total Medicine Days/1,000	11.41	8.97	6.30	19.17	15.79
Total Medicine Average Length of Stay	4.16	4.18	4.32	3.92	4.68
Total Surgery Discharges/1,000	1.33	1.00	0.52	2.63	2.10
Total Surgery Days/1,000	10.90	6.80	3.34	24.87	20.81
Total Surgery Average Length of Stay	8.19	6.83	6.43	9.44	9.92
Total Maternity Discharges/1,000	3.40	3.23	2.57	2.72	2.96
Total Maternity Days/1,000	8.51	8.20	6.17	6.48	8.29
Total Maternity Average Length of Stay	2.50	2.54	2.40	2.39	2.80
Mental Health Utilization[4]					
Mental Health Utilization—Total (Any Services)	8.29%	9.98%	6.00%	10.50%	9.87%

Table 4-7—Comparison of HEDIS 2015 Non-ABD Rates Under Utilization					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Mental Health Utilization—Total (Inpatient Services)	0.41%	0.42%	0.33%	0.82%	0.60%
Mental Health Utilization—Total (Intensive Outpatient Services)	0.08%	0.09%	0.00%	0.04%	0.06%
Mental Health Utilization—Total (Ambulatory/ED Visits)	8.12%	9.85%	5.99%	10.18%	9.60%
Plan All-Cause Readmissions					
PCR Total[1,2,3]	11.99%	11.27%	15.59%	16.01%	13.79%

[1]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[2]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Commercial weights for the non-ABD population.*

[3]*A lower rate indicates better performance for this measure.*

[4]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

Note: Kaiser received approval from the MQD to report nine measures via the Administrative methodology. These measures were CIS, CCS, COL, CDC, HPV, FPC, IMA, W15, and W34.

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red***. Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green***.*

EFFECTIVENESS OF CARE

Table 4-8 displays the Effectiveness of Care performance measure results for the non-ABD populations, compared to the national Medicaid percentiles. Medicaid national percentiles do not exist for the *Colorectal Cancer Screening* measure; therefore, no comparisons to percentiles were performed. Only HMSA reported valid rates for all 23 Effectiveness of Care indicators. AlohaCare, Kaiser, 'Ohana, and UHC CP were not able to report valid rates for 2, 6, 10, and 13 of the indicators, respectively, due to having fewer than 30 members in the denominator. Kaiser reported rates that were above the HEDIS 2014 Medicaid 90th percentile for nine of the 16 indicators that were compared to the national Medicaid percentiles, and reported rates for two indicators that were below the 25th percentile. Both AlohaCare and 'Ohana reported six rates that fell below the 25th percentile. HMSA and UHC CP reported 11 and three rates, respectively, that fell below the 25th percentile.

Table 4-8—Comparison of HEDIS 2015 Non-ABD Rates Under Effectiveness of Care					
	AlohaCare	HMSA	Kaiser	'Ohana	UHC CP
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	**17.95%**	**32.83%**	NA	**43.24%**	**30.30%**
Adult BMI Assessment					
Adult BMI Assessment	83.94%	**69.21%**	**97.21%**	81.02%	80.29%
Annual Monitoring for Patients on Persistent Medications					
ACE Inhibitors or ARBs	86.91%	89.13%	91.04%	86.67%	86.53%

Table 4-8—Comparison of HEDIS 2015 Non-ABD Rates Under Effectiveness of Care					
	AlohaCare	HMSA	Kaiser	‘Ohana	UHC CP
Digoxin	NA	**42.25%**	NA	NA	NA
Diuretics	85.75%	87.32%	90.22%	**84.62%**	88.69%
Total	86.12%	87.98%	**90.44%**	84.95%	86.64%
Antidepressant Medication Management					
Effective Acute Phase Treatment	45.45%	46.97%	47.64%	48.28%	54.55%
Effective Continuation Phase Treatment	31.67%	31.45%	36.32%	33.91%	32.58%
Colorectal Cancer Screening					
Colorectal Cancer Screening[1]	26.76%	43.80%	70.66%	24.57%	25.36%
Follow-Up After Hospitalization for Mental Illness					
7 Days	**20.59%**	**29.30%**	**65.82%**	32.73%	**24.47%**
30 Days	**41.18%**	**49.30%**	75.95%	**47.27%**	**47.87%**
Follow-Up of Care for Children Prescribed ADHD Medication					
Initiation Phase	40.38%	34.17%	**55.32%**	NA	NA
Continuation Phase	NA	**35.29%**	NA	NA	NA
Medication Management for People With Asthma					
Medication Compliance 50%	54.42%	56.54%	**33.75%**	**40.00%**	NA
Medication Compliance 75%	30.45%	31.56%	**13.25%**	**16.67%**	NA
Persistence of Beta Blocker Treatment After a Heart Attack					
Persistence of Beta Blocker Treatment After a Heart Attack	88.00%	**73.08%**	NA	NA	NA
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	70.11%	70.80%	NA	NA	NA
Bronchodilator	83.91%	88.32%	NA	NA	NA
Use of Appropriate Medications for People With Asthma					
5–11 years	**74.72%**	**80.81%**	**98.04%**	NA	NA
12–18 years	**71.54%**	**76.24%**	**98.94%**	NA	NA
19–50 years	71.43%	**68.92%**	**96.72%**	NA	NA
51–64 years	80.22%	76.65%	**92.86%**	NA	NA
Total	**73.45%**	**74.73%**	**97.32%**	**65.22%**	NA

[1]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Note: Kaiser received approval from the MQD to report nine measures via the Administrative methodology. These measures were CIS, CCS, COL, CDC, HPV, FPC, IMA, W15, and W34.

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red***. Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green***.*

ABD HEDIS Performance Measures

CHILDREN'S PREVENTIVE CARE

Table 4-9 displays the Children's Preventive Care performance measure results for the ABD populations, compared to the national Medicaid percentiles. For the *Well Child Visits in the First 15 Months of Life—Zero Visits* indicator, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied. 'Ohana reported valid rates for 27 of the 29 Children's Preventive Care indicators, but was unable to report valid rates for the two indicators in the *Well Child Visits in the First 15 Months of Life* measure due to having fewer than 30 members in the denominator. UHC CP was only able to report valid rates for 8 of the 29 indicators due to having too few members in the denominator for all indicators in the *Childhood Immunization Status* and *Well Child in the First 15 Months of Life* measures. Neither health plan reported rates that ranked above the HEDIS 2014 Medicaid 90th percentile. For 'Ohana, 56 percent (15 of 27 indicators) of reported rates fell below the 25th percentile, and for UHC CP, 75 percent (six of eight indicators) of its reported rates fell below the 25th percentile.

Table 4-9—Comparison of HEDIS 2015 ABD Rates Under Children's Preventive Care

	'Ohana	UHC CP
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	45.74%	**36.57%**
Childhood Immunization Status		
DTaP	79.49%	NA
IPV	**82.05%**	NA
MMR	**87.18%**	NA
HiB	**84.62%**	NA
Hepatitis B	**79.49%**	NA
VZV	**84.62%**	NA
Pneumococcal Conjugate	79.49%	NA
Hepatitis A	76.92%	NA
Rotavirus	**43.59%**	NA
Influenza	64.10%	NA
Combination #2	**69.23%**	NA
Combination #3	**66.67%**	NA
Combination #4	61.54%	NA
Combination #5	**35.90%**	NA
Combination #6	51.28%	NA
Combination #7	**33.33%**	NA
Combination #8	51.28%	NA
Combination #9	**25.64%**	NA
Combination #10	**25.64%**	NA

Table 4-9—Comparison of HEDIS 2015 ABD Rates Under Children's Preventive Care		
	'Ohana	UHC CP
Immunization for Adolescents		
Meningococcal	**59.04%**	**45.45%**
Tdap/Td	**65.06%**	**49.09%**
Combined	**56.63%**	**41.82%**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation	74.70%	53.87%
Counseling for Nutrition	56.93%	51.03%
Counseling for Physical Activity	50.61%	**34.02%**
Well-Child Visits in the First 15 Months of Life		
0 Visits[1]	NA	NA
6 or More Visits	NA	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.07%	**63.36%**

[1]*A lower rate indicates better performance for this measure.*

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red***. Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green***.*

WOMEN'S HEALTH

Table 4-10 displays the Women's Health performance measure results for ABD populations, compared to the national Medicaid percentiles. 'Ohana reported valid rates for five of the six Women's Health indicators. UHC CP reported valid rates for four of the six indicators. Both health plans were unable to report valid rates for the *Human Papillomavirus Vaccine for Female Adolescents* measure due to having fewer than 30 members in the denominator, and UHC CP was also unable to report a valid rate for the *Chlamydia Screening in Women—16–20 Years* indicator. Neither health plan reported rates that ranked above the HEDIS 2014 Medicaid 90th percentile. For 'Ohana, 60 percent (three of five indicators) of reported rates fell below the HEDIS 2014 Medicaid 25th percentile, compared to 75 percent (three of four indicators) for UHC CP.

Table 4-10—Comparison of HEDIS 2015 ABD Rates Under Women's Health		
	'Ohana	UHC CP
Breast Cancer Screening		
Breast Cancer Screening	56.41%	58.68%
Cervical Cancer Screening		
Cervical Cancer Screening	58.78%	**48.94%**
Chlamydia Screening in Women		
16–20 Years	**33.33%**	NA
21–24 Years	**38.71%**	**41.30%**
Total	**36.13%**	**31.51%**

Table 4-10—Comparison of HEDIS 2015 ABD Rates Under Women's Health		
	'Ohana	UHC CP
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	NA	NA

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

CARE FOR CHRONIC CONDITIONS

Table 4-11 displays the Care for Chronic Conditions performance measure results for the ABD populations, compared to the national Medicaid percentiles. For the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* indicator, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied. Both health plans reported valid rates for all eight Care for Chronic Conditions indicators. Both health plans reported one rate that ranked above the HEDIS 2014 Medicaid 90th percentile, and neither plan reported rates that fell below the HEDIS 2014 Medicaid 25th percentile.

Table 4-11—Comparison of HEDIS 2015 ABD Rates Under Care for Chronic Conditions		
	'Ohana	UHC CP
Comprehensive Diabetes Care		
HbA1c Testing	87.93%	84.20%
HbA1c Poor Control (>9.0%)[1]	37.07%	31.08%
HbA1c Control (<8.0%)	52.66%	**59.38%**
HbA1c Control (<7.0%)	37.71%	38.50%
Eye Exam	60.58%	64.76%
Nephropathy	**88.87%**	85.24%
Blood Pressure Control (<140/90)	62.77%	63.37%
Controlling High Blood Pressure		
Controlling High Blood Pressure	61.01%	57.77%

[1] *A lower rate indicates better performance for this measure.*

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

ACCESS TO CARE

Table 4-12 displays the Access to Care performance measure results for the ABD populations, compared to the national Medicaid percentiles. Both health plans reported valid rates for 11 of the 12 Access to Care indicators. Neither health plan reported a valid rate for the *Children and Adolescents' Access to Primary Care Practitioners—12–24 months* indicator due to having fewer than 30 members in the denominator. 'Ohana reported one rate that ranked above the HEDIS Medicaid 90th percentile and one rate that fell below the HEDIS Medicaid 25th percentile. UHC CP reported two rates that ranked above the 90th percentile compared to seven rates that fell below the 25th percentile.

Table 4-12—Comparison of HEDIS 2015 ABD Rates Under Access to Care		
	'Ohana	UHC CP
Adults' Access to Preventive/Ambulatory Health Services		
20–44 years	83.68%	83.94%
45–64 years	91.22%	92.13%
65+ years	91.65%	**95.61%**
Total	**89.84%**	**92.71%**
Children and Adolescents' Access to Primary Care Practitioners		
12–24 months	NA	NA
25 months–6 years	90.08%	**73.47%**
7–11 years	89.53%	**72.73%**
12–19 years	86.82%	**73.18%**
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment	**33.22%**	**31.77%**
Engagement of AOD Treatment	6.08%	**4.56%**
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	80.65%	**48.48%**
Postpartum Care	58.06%	**51.52%**

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

UTILIZATION

Table 4-13 displays the Utilization performance measure results for the ABD populations, compared to the national Medicaid percentiles. For the *Ambulatory Care—ED Visits/1,000* and *Frequency of Ongoing Prenatal Care—<21 Percent* indicators, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied. The *Enrollment by Product Line*, *Inpatient Utilization—General Hospital/Acute Care*, and *Mental Health Utilization* measures are presented for informational purposes only, so no comparisons to HEDIS 2014 percentiles were performed. Further, Medicaid national percentiles do not exist for *Plan All-Cause Readmission*, so no comparisons to percentiles were performed.

Both health plans reported valid rates for all 25 Utilization indicators. Of the four indicators that were compared to the Medicaid HEDIS 2014 percentiles, both plans reported one rate that ranked above the 90th percentile and two rates that fell below the 25th percentile. Both plans reported a rate that was above the 90th percentile for the *Ambulatory Care—Outpatient Visits/1,000* indicator, and both plans performed below average on the *Frequency of Ongoing Prenatal Care—81+ Percent* indicator, reporting a rate that fell below the 25th percentile.

Table 4-13—Comparison of HEDIS 2015 ABD Rates Under Utilization		
	'Ohana	UHC CP
Ambulatory Care		
ED Visits/1,000[3]	**75.15**	63.79
Outpatient Visits/1,000	**716.22**	**780.76**

Table 4-13—Comparison of HEDIS 2015 ABD Rates Under Utilization		
	'Ohana	UHC CP
Enrollment by Product Line[1]		
0-19 years	0.11	0.06
20-44 years	0.18	0.14
45-64 years	0.35	0.31
65+ years	0.36	0.48
Frequency of Ongoing Prenatal Care		
<21 Percent[3]	6.45%	**66.67%**
81+ Percent	**32.26%**	**9.09%**
Inpatient Utilization-General Hospital/Acute Care[4]		
Total Inpatient Discharges/1,000	24.13	18.97
Total Inpatient Days/1,000	185.84	170.29
Total Inpatient Average Length of Stay	7.70	8.98
Total Medicine Discharges/1,000	16.70	15.12
Total Medicine Days/1,000	93.15	126.89
Total Medicine Average Length of Stay	5.58	8.39
Total Surgery Discharges/1,000	7.22	3.67
Total Surgery Days/1,000	92.05	43.02
Total Surgery Average Length of Stay	12.75	11.71
Total Maternity Discharges/1,000	0.34	0.36
Total Maternity Days/1,000	1.08	0.77
Total Maternity Average Length of Stay	3.13	2.15
Mental Health Utilization[4]		
Mental Health Utilization—Total (Any Services)	20.99%	17.90%
Mental Health Utilization—Total (Inpatient Services)	1.88%	1.58%
Mental Health Utilization—Total (Intensive Outpatient Services)	0.06%	0.02%
Mental Health Utilization—Total (Ambulatory/ED Visits)	20.16%	17.04%
Plan All-Cause Readmissions		
PCR Total[1,2,3]	19.09%	15.61%

[1]*Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

[2]*This measure requires risk adjustment; however, standardized risk adjustment weights are not currently available for Medicaid. The MQD required this measure to be reported applying the Medicare weights for the ABD population.*

[3]*A lower rate indicates better performance for this measure.*

[4]*Results are presented for informational purposes only. Benchmarking these rates is not applicable because performance should be assessed based on individual health plan characteristics.*

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

EFFECTIVENESS OF CARE

Table 4-14 displays the Effectiveness of Care performance measure results for the ABD populations, compared to the national Medicaid percentiles. Medicaid national percentiles do not exist for the *Care for Older Adults*, *Colorectal Cancer Screening*, and *Medication Reconciliation Post-Discharge* measures; therefore, no comparisons to percentiles were performed.

Both plans reported valid rates for 25 of the 29 Effectiveness of Care indicators. Neither plan reported valid rates for the *Follow-Up of Care for Children Prescribed ADHD Medication* measure and the *Use of Appropriate Medication for People With Asthma—5–11 years* and *12–18 years* indicators due to having fewer than 30 members in the denominator. Both 'Ohana and UHC CP performed similarly on the Effectiveness of Care measures. Both plans reported rates that ranked above the HEDIS 2014 Medicaid 90th percentile for the same five indicators. Both plans also reported rates that fell below the 25th percentile for three indicators.

Table 4-14—Comparison of HEDIS 2015 ABD Rates Under Effectiveness of Care

	'Ohana	UHC CP
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	**75.56%**	**75.64%**
Adult BMI Assessment		
Adult BMI Assessment	81.49%	82.99%
Annual Monitoring for Patients on Persistent Medications		
ACE Inhibitors or ARBs	91.93%	91.51%
Digoxin	**49.59%**	**51.37%**
Diuretics	**92.72%**	**92.40%**
Total	**91.17%**	**90.87%**
Antidepressant Medication Management		
Effective Acute Phase Treatment	54.32%	46.37%
Effective Continuation Phase Treatment	41.35%	40.48%
Care for Older Adults[1]		
Advance Care Planning	23.60%	60.65%
Medication Review	71.78%	79.40%
Functional Status Assessment	63.75%	69.68%
Pain Assessment	81.75%	81.71%
Colorectal Cancer Screening[1]		
Colorectal Cancer Screening	37.23%	47.10%
Follow-Up After Hospitalization for Mental Illness		
7 Days	32.11%	37.22%
30 Days	51.58%	56.11%
Follow-Up of Care for Children Prescribed ADHD Medication		
Initiation Phase	NA	NA

Table 4-14—Comparison of HEDIS 2015 ABD Rates Under Effectiveness of Care		
	‘Ohana	UHC CP
Continuation Phase	NA	NA
Medication Management for People With Asthma		
Medication Compliance 50%	**70.83%**	**70.63%**
Medication Compliance 75%	**45.83%**	**46.85%**
Medication Reconciliation Post-Discharge[1]		
Medication Reconciliation Post-Discharge	32.36%	21.81%
Persistence of Beta Blocker Treatment After a Heart Attack		
Persistence of Beta Blocker Treatment After a Heart Attack	92.00%	94.37%
Pharmacotherapy Management of COPD Exacerbation		
Systemic Corticosteroid	72.37%	70.83%
Bronchodilator	85.99%	83.33%
Use of Appropriate Medications for People With Asthma		
5–11 years	NA	NA
12–18 years	NA	NA
19–50 years	71.00%	77.65%
51–64 years	74.56%	**63.92%**
Total	**74.71%**	**72.22%**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	**21.05%**	28.57%

[1] *Results are presented for informational purposes only. These rates do not have applicable benchmarks for comparison.*

Rates ranking below the national HEDIS 2014 Medicaid 25th percentile are colored in bold **red**. *Rates ranking above the national HEDIS Medicaid 90th percentile are colored in bold* **green**.

Validation of Performance Improvement Projects

Validity of Performance Improvement Projects for QUEST Integration Health Plans

HSAG conducted a review of two PIPs for each of the five QUEST Integration plans—AlohaCare, HMSA, Kaiser, 'Ohana, and UHC CP. The topics for each were *All-Cause Readmissions* and *Diabetes Care*. For the 2015 validation, all QI health plans passed modules 1 through 3 for each PIP topic and had progressed to Module 4, Intervention Testing, in August 2015.

Validity of Performance Improvement Projects for the CCS Program

HSAG conducted a review of two PIPs for the CCS program. The topics were *Follow-Up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*. For the 2015 validation, CCS passed modules 1 through 3 for each PIP topic and had progressed to Module 4, Intervention Testing, in August 2015.

Performance Improvement Projects Outcomes

2015 was a transition year; the health plans moved 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 2015 validation process. In August 2015, all health plans progressed to testing interventions by conducting PDSA in Module 4. The health plans will submit to HSAG a Module 4 summary for each intervention that is tested. When the PDSA cycles for testing interventions have been completed, the health plans will submit Module 5 with the PIP outcomes, lessons learned, conclusions, and plans for sustaining and spreading changes that led to improvement. Therefore, outcome data and health plan comparative information will be available in the 2016 annual report of results.

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

Top-Box Comparisons

QI HEALTH PLANS

Table 4-15 presents the question summary rates and global proportions for each QI health plan and the QI Program aggregate.[4-1]

Table 4-15—Comparison of 2015 QUEST Integration Child CAHPS Results

	AlohaCare QI	HMSA QI	Kaiser QI	'Ohana QI	UHC CP QI	QI Program Aggregate
Global Ratings						
Rating of Health Plan	70.0%	74.3% ↑	75.9% ↑	56.8% ↓	61.1% ↓	68.7%
Rating of All Health Care	65.1%	69.6% ↑	72.0% ↑	54.7% ↓	62.9%	65.5%
Rating of Personal Doctor	74.2%	76.7%	83.1% ↑	65.9% ↓	77.0%	76.0%
Rating of Specialist Seen Most Often	61.1%+	74.6%+	77.6%+	69.0%	78.7%+	72.5%
Composite Measures						
Getting Needed Care	76.4%	84.5%	82.4%	76.0%	82.8%	80.3%
Getting Care Quickly	80.4% ↓	87.7%	90.2% ↑	84.0%	84.9%	85.8%
How Well Doctors Communicate	94.4%	94.0%	96.5% ↑	90.6% ↓	93.0%	93.9%
Customer Service	77.0% ↓	91.8% ↑	88.8% ↑	79.0%	82.1%	83.1%
Shared Decision Making	85.5%+	79.0%+	86.8%	82.8%	78.5%+	82.4%
Individual Item Measures						
Coordination of Care	89.9%+	88.2%	89.8%	80.8%	84.7%+	86.6%
Health Promotion and Education	80.7%	70.2% ↓	80.0%	75.6%	81.0%	77.1%

+ The health plan had fewer than 100 respondents for a measure; therefore, caution should be exercised when interpreting these results.
Due to changes to the *Shared Decision Making* composite, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.
Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2014 NCQA national child Medicaid average.
↑ Indicates that the score is higher than the QI Program aggregate by a statistically significant degree.
↓ Indicates that the score is lower than the QI Program aggregate by a statistically significant degree.

[4-1] The QI Program aggregate results were derived from the combined results of the five participating QI health plans.

Comparison of the QI Program aggregate, AlohaCare QI, HMSA QI, Kaiser QI, ‘Ohana QI, and UHC CP QI scores to the 2014 NCQA national child Medicaid average revealed the following:

- 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 child 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.*

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

- AlohaCare QI scored significantly lower than the QI Program aggregate on two measures: *Getting Care Quickly* and *Customer Service*.
- HMSA QI scored significantly higher than the QI Program aggregate on three measures: *Rating of Health* Plan, *Rating of All Health Care,* and *Customer Service.*
- Kaiser QI scored significantly higher than the QI Program aggregate on six measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Getting Care Quickly, How Well Doctors Communicate*, and *Customer Service.*
- ‘Ohana QI scored significantly lower than the QI Program aggregate on four measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor*, and *How Well Doctors Communicate.*
- UHC CP QI scored significantly lower than the QI Program aggregate on one measure: *Rating of Health Plan.*

CHILD HEALTH INSURANCE PROGRAM (CHIP) STATEWIDE SURVEY

Table 4-16 presents the question summary rates and global proportions for the Hawaii CHIP population.

Table 4-16—Comparison of 2015 CHIP CAHPS Results

	2015 CHIP
Global Ratings	
Rating of Health Plan	69.5%
Rating of All Health Care	65.3%
Rating of Personal Doctor	75.1%
Rating of Specialist Seen Most Often	59.3%+
Composite Measures	
Getting Needed Care	81.5%
Getting Care Quickly	85.6%
How Well Doctors Communicate	93.8%
Customer Service	84.9%
Shared Decision Making	79.9%
Individual Item Measures	
Coordination of Care	83.2%
Health Promotion and Education	73.3%

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

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

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2014 NCQA national child Medicaid average.

Comparison of the CHIP scores to the 2014 NCQA national child Medicaid average revealed the following:

- Hawaii's 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*.

NCQA Comparisons

QI HEALTH PLANS[4-2]

Table 4-17 presents the overall member satisfaction ratings for the QI Program aggregate and each health plan on each of the four global ratings.

Table 4-17—NCQA Comparisons: Global Ratings

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

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

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

Table 4-18 presents the overall member satisfaction ratings for the QI Program aggregate and each health plan on the four composite measures.

Table 4-18—NCQA Comparisons: Composite Measures

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

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

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

[4-2] Because NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, star ratings cannot be assigned.

CHIP[4-3,4-4]

Table 4-19 presents the overall member satisfaction ratings for the Hawaii CHIP population on each of the four global ratings.

Table 4-19—NCQA Comparisons: Global Ratings

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

Note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there were fewer than 100 respondents for a measure, caution should be exercised when interpreting these results.

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

Table 4-19 presents the overall member satisfaction ratings for the Hawaii CHIP population on each of the four composite measures.

Table 4-20—NCQA Comparisons: Composite Measures

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

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

[4-3] Because NCQA does not provide benchmarking information for the *Shared Decision Making* composite measure and the *Coordination of Care* and *Health Promotion and Education* individual item measures, star ratings cannot be assigned.

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

Provider Survey

QI HEALTH PLANS

Table 4-21 presents a summary of the statistically significant differences that exist between the "top-box" rates (i.e., percent satisfied) of health plans.

Table 4-21—Plan Comparisons Summary of Results

	AlohaCare QI		HMSA QI		Kaiser QI		'Ohana QI		'Ohana CCS		UHC CP QI	
General Positions[4-5]												
Compensation Satisfaction	23.3%	—	51.7%	▲	36.1%	▲	17.4%	▼	13.4%	▼	14.1%	▼
Timeliness of Claims Payments	40.5%	—	65.1%	▲	38.2%	—	32.0%	▼	28.0%	▼	28.6%	▼
Providing Quality Care												
Prior Authorization Process	16.3%	—	26.6%	▲	28.9%	▲	10.7%	▼	11.5%	—	5.5%	▼
Formulary	9.9%	—	17.4%	—	31.8%	▲	9.8%	—	8.8%	—	8.1%	▼
Formulary												
Adequate Access to Non-Formulary Drugs	3.8%	▼	10.4%	—	39.0%	▲	2.3%	▼	1.3%	▼	4.2%	▼
Service Coordinators												
Helpfulness of Service Coordinators	16.5%	—	31.7%	▲	45.8%	▲	11.4%	▼	8.3%	▼	10.0%	▼
Specialists												
Adequacy of Specialists	9.8%	▼	35.8%	▲	57.4%	▲	7.3%	▼	11.5%	—	10.8%	▼
Adequacy of Behavioral Health Specialists	5.6%	—	10.0%	—	21.3%	▲	2.7%	—	4.3%	—	3.1%	—
Behavioral Health												
Adequacy of Licensed Behavioral Health Providers	7.5%	—	15.2%	—	28.5%	▲	4.0%	▼	4.7%	▼	4.2%	▼

▲ *indicates the plan's top-box rate is significantly higher than the aggregate of the other plans.*
— *indicates the plan's top-box rate is not significantly different than the aggregate of the other plans.*
▼ *indicates the plan's top-box rate is significantly lower than the aggregate of the other plans.*

[4-5] For purposes of the *Compensation Satisfaction* and *Timeliness of Claims Payments* plan comparisons, the health plans' results were compared to the aggregate performance of the other Medicaid health plans and contracted commercial managed care health plans.

The following is a summary of plan performance on the nine measures evaluated for statistical differences:

- AlohaCare QI's top-box rate was significantly lower than the aggregate performance of the other plans on two measures.
- HMSA QI's top-box rate was significantly higher than the aggregate performance of the other plans on five measures.
- Kaiser QI's top-box rate was significantly higher than the aggregate performance of the other plans on eight measures.
- 'Ohana QI's top-box rate was significantly lower than the aggregate performance of the other plans on seven measures.
- 'Ohana CCS' top-box rate was significantly lower than the aggregate performance of the other plans on five measures.
- UHC CP QI's top-box rate was significantly lower than the aggregate performance of the other plans on eight measures.

Table 4-22 presents a summary of the trend analysis. Each plan's 2015 Provider Survey results were compared to their corresponding 2013 Provider Survey results.[4-6,4-7]

Table 4-22—Trend Analysis Summary of Results

	AlohaCare QI	HMSA QI	Kaiser QI	'Ohana QI	'Ohana CCS	UHC CP QI
General Positions[4-8]						
Compensation Satisfaction	↔	↔	↔	↔	↔	↔
Timeliness of Claims Payments	↔	↔	↔	↔	↔	↔
Providing Quality Care						
Prior Authorization Process	↔	↔	↔	↔	↔	↔
Formulary	↔	↔	↔	↔	↔	↔
Formulary						
Adequate Access to Non-Formulary Drugs	↔	↔	↔	↔	↔	↔
Service Coordinators						
Helpfulness of Service Coordinators						
Specialists						
Adequacy of Specialists	↔	↔	↔	↔	↔	↔
Adequacy of Behavioral Health Specialists	↔	↔	↔	↔	↔	↔
Behavioral Health						
Adequacy of Licensed Behavioral Health Providers						

↑ *indicates the 2015 top-box rate is significantly higher than the 2013 top-box rate.*
↔ *indicates the 2015 top-box rate is not significantly different than the 2013 top-box rate.*
↓ *indicates the 2015top-box rate is significantly lower than the 2013 top-box rate.*

[4-6] The provider survey was not administered in 2014.
[4-7] It should be noted that a trend analysis could not be performed for the *Helpfulness of Service Coordinators* and *Adequacy of Licensed Behavioral Health Providers* measures since these are new measures for 2015.
[4-8] For purposes of the *Compensation Satisfaction* and *Timeliness of Claims Payments* plan comparisons, the health plans' results were compared to the aggregate performance of the other Medicaid health plans and contracted commercial managed care health plans.

Comparison of the QI health plan's 2015 top-box rates to their corresponding 2013 top-box rates on the seven measures evaluated for statistically significant differences revealed the following summary results:

- AlohaCare QI, HMSA QI, Kaiser QI, 'Ohana QI, 'Ohana CCS, and UHC CP QI did not score significantly higher or lower in 2015 than in 2013 on any of the measures.

5. Assessment of Follow-Up to Prior Year Recommendations

Introduction

This section of the annual report presents an assessment of how effectively the (formerly) QUEST and QExA health plans addressed the improvement recommendations made by HSAG in the prior year (2014) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, and CAHPS. The provider survey was not performed in 2014 and, therefore, is not addressed in this section. The CCS program members were not separately sampled for the CAHPS survey, as they were included in the QExA health plans' sampling; therefore, there are not separate CAHPS results related to CCS members.

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

2014 Compliance Monitoring Review

Formal follow-up reevaluations of the health plans' corrective actions to address the deficiencies identified in the 2014 compliance reviews and in the remaining CAPs carried over to 2015 (for AlohaCare, Kaiser, and 'Ohana only) were completed by HSAG in mid- to late 2014 and early 2015. All health plans were found to have sufficiently addressed and corrected their findings of deficiencies (results reported in the 2014 Hawaii External Quality Review Report of Results) through implementation of corrective action plans and were found to be in full compliance with requirements during the reevaluations conducted by HSAG. Next year, 2016, will begin a new three-year cycle for monitoring of compliance with federal and State managed care standards.

2014 Validation of Performance Measures—NCQA HEDIS Compliance Audits

AlohaCare

AlohaCare's HEDIS Performance Measures Recommendations

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

Improvement Activities Implemented:

In preparation for its NCQA accreditation, AlohaCare transformed its entire organization related to the authority and accountability for the quality of services provided to members as well as its oversight of the development, implementation, and evaluation of the Quality Improvement (QI) Program. The health plan's Quality Improvement Department also went through restructuring, aiming to better engage staff in its continuous quality improvement program.

With the assistance of a HEDIS consultant and together with the health plan's HEDIS software vendor, AlohaCare developed and implemented a plan focused on maximizing its performance in the HEDIS season:

New Supplemental Data

1. Data Warehouse—AlohaCare initiated dialogue with select Community Health Centers (CHCs) about the possibility of receiving data dumps on a routine basis throughout the year. Four CHCs expressed interest and agreed to use MediSense as the data warehouse. A minor error was detected and, although fixed, due to the timing of this implementation and the requirements of NCQA's HEDIS timeline, the process could not be used for 2015 and will be pursued for HEDIS 2016.

2. State Registry—AlohaCare pursued using the State Registry but, because of data entry errors, decided against its use for HEDIS 2015. AlohaCare plans to use the State Registry for HEDIS 2016, with quality checks along the way to ensure accuracy of the data entered.

3. Pay for Performance—During the last quarter of 2014, AlohaCare implemented an incentive project for the QUEST population providers. *Childhood Immunizations—Combo 2*, *Chlamydia*, and the two components of *Comprehensive Diabetes Care* were included, for the time period of October–December 2014.

   In February 2015, AlohaCare implemented a three-year QUEST incentive Program for all providers. The measures selected for incentives were *Childhood Immunizations—Combo 2*, *Controlling High Blood Pressure*, two components of *Comprehensive Diabetes Care*, and

Frequency of Prenatal Care. 2015 will be the baseline year. In the second and third years, the incentive will be determined by individual provider's improvement from baseline rates. As part of the incentive program, the providers were asked to submit supporting documents (medical records); the medical records are being sent to AlohaCare's HEDIS vendor.

AlohaCare has a process in place to evaluate the previous year's data and analyze root causes to rule out system/process gaps. The health plan has identified some areas to focus on next year.

HEDIS 2016 interventions will include:

a. Data (claims, medical records) being submitted from the providers.
b. Internal process of maintaining the providers' contact information and status.
c. Use of supplemental data (EMR data and State Registry) will include quality checks.

HMSA

HMSA's HEDIS Performance Measures Recommendations

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

Improvement Activities Implemented:

Childhood Immunization Status

HMSA reported that the childhood immunization status measure continues to be challenging from a data perspective. Because vaccinations are covered through Vaccines for Children (VFC), HMSA relies on the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) form for information about vaccinations administered. Through its reviews over the years, HMSA has found that the vaccination information provided does not always accurately reflect a child's immunization record, and without complete information the health plan has been unable to have meaningful engagement with members and providers.

To address the incomplete vaccination data, HMSA has implemented ongoing provider educational interventions. In addition, HMSA has used its data to predict which immunizations were likely given. In part to gather data and in part as an intervention, HMSA conducted outreach to all providers with patients under 2 years of age who had not yet received their full vaccinations. Providers were given a list of true negatives, while both true negatives and false negatives were taken back to revise the prediction.

The resulting prediction was used to focus provider and member intervention efforts. Members were characterized as high-risk, medium-risk, and low-risk based on the pattern of vaccinations over time. High- and medium-risk members received phone calls to remind them of the need for vaccinations. All members received routine reminders about vaccinations.

Providers who were not shown to be high performers through HMSA's hybrid chart reviews and pay-for-quality program outcome received educational visits to review their processes. At the same time, information on office practices was gathered for broader improvement activities. In addition, providers received lists of children who need vaccinations. Providers could sort and select children by risk level and by time frame.

Comprehensive Diabetes Care

HMSA's data analysis identified that diabetes A1c testing rates have been improving, indicating that the focus of interventions should be on A1c control. To monitor testing rates, HMSA received lab data files monthly from Diagnostic Laboratories Services and Clinical Laboratories.

Comprehensive Diabetes Care is multifaceted and includes medication choice, medication adherence, medication acceleration and lifestyle changes. For medication adherence, HMSA collaborated with its partner, CVS Caremark. Physicians received notification when a member's first prescription was returned to stock (primary nonadherence). Physicians were also notified when a member failed to pick up a refill for an antidiabetic medication. Members received notification when a refill was not picked up.

To address medication choice and medication acceleration, HMSA's approach was to present the provider with data and ask the physician to facilitate an informed treatment decision with their patient. To that end, HMSA developed a prototype report that showed the provider his/her diabetes caseload, depicted where the patient was along the ADA guideline related to medication choice and acceleration, and identified groups of patients for treatment modification. HMSA is currently developing this prototype further based on physician feedback and plans to pilot the prototype report with select providers.

For lifestyle changes, HMSA offered and encouraged wellbeing connection. This included telephonic health coaching and health education workshops which were available to support members in attaining their health goals.

Kaiser

Kaiser's HEDIS Performance Measures Recommendations

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

Improvement Activities Implemented

Kaiser has identified the following SMART Aim as part of the 2015 Performance Improvement Project (PIP): By June 30, 2016, increase the percentage of QUEST Integration members with a Hemoglobin A1c < 8 from 51 percent to 60 percent at Nanaikeola Clinic who have Provider A, B, and C as their PCP.

To address the 2015 *Diabetes Care* PIP, Kaiser has (1) identified the key drivers and interventions, (2) developed the data collection process, and (3) determined failures that warrant quality improvement. See below for a summary on each of the three phases.

I. Key Drivers and Interventions

Key Drivers:

1. Medications
2. Continuity of Care
3. Member Education and Engagement
4. Provider Awareness
5. Access

Interventions:

1. Synchronize medication refills for all medications to streamline the process for members and decrease medication confusion around when medications are due to be refilled.
2. Dispense 90-day supply of medication to members to ensure better compliance.
3. Encourage members to sign up for mail order service, which sends medications directly to the member's home via U.S. mail.
4. Patient Support Services (PSS) staff based in the clinic will introduce themselves to the member and focus on educating and supporting the member with managing diabetes through telephonic support.

5. Kaiser's PSS unit will round with PCPs regularly about the members they support. This partnership will provide PCPs with awareness of members' challenges and elicit their suggestions.
6. Service coordinators will assist members in eliminating barriers to keeping clinic appointments, engaging with PSS, and filling their medications. Service coordinators will perform home visits for members that PSS staff has difficulty contacting.

II. Data Collection Process

1. On the tenth business day of each month, the Kaiser pharmacy analyst will extract from the Kaiser Disease Registry (aka "Mana ku") a list of eligible QUEST Integration diabetes members, with Hemoglobin Alc > 8, home clinic location of Nanaikeola, and Provider A, B or C as their PCP. The pharmacy analyst will send the list via secured encrypted email to the PSS staff. Throughout the month, the PSS staff will outreach to the identified QUEST Integration members with Hemoglobin A1c > 8. The PSS staff will contact the member via telephone. After two unsuccessful telephone calls, a letter will be sent requesting the member call the clinic.
2. The rate calculation will be performed by the pharmacy analyst using the Microsoft Excel spreadsheet formula division function and the result will be that month's percentage of eligible QUEST Integration diabetes members with Hemoglobin A1c rates < 8 with home location of Nanaikeola who have Provider A, B, or C as their PCP.
3. The SMART Aim will reach meaningful improvement when the SMART Aim goal has been met.

III. Intervention Determination

Kaiser has developed a high-level process map from the perspective of the customer that captures where breakdowns in the process may occur that would affect diabetes care. From this map, three sub-processes were selected that had the most potential to make the greatest impact. Failure modes, causes, effects and priorities were also identified for each sub-process. Based on these results the failures modes were ranked from the highest priority to the lowest, and the failure modes that warranted quality improvement were identified. The result of this analysis is the final Intervention Determination captured below.

Intervention Determination		
Failures	**Potential Interventions**	**Consideration for Reliability**
Patient isn't ordering medication refills	Dispense 90-day supply of medication	Dispensing a three-month supply will increase likelihood of medication compliance since member doesn't have to go to clinic every month for medication refill.
Patient isn't picking up medication refills from clinic	Send medication refills to patient via mail. (Mail order)	Receiving medications via U.S. mail will eliminate barriers that make it difficult for patient to pick up medication at clinic.
Patient isn't taking medications	PSS staff will assess barriers to medication compliance. (i.e., intolerance to medication or side effects)	Barriers to medication compliance may be eliminated, and this will increase the likelihood of medication regimen compliance.

'Ohana

'Ohana HEDIS Performance Measures Recommendations

QUEST

'Ohana reported valid rates for 35 of the 36 measures/indicators. Of these 35 rates, 25 were below the national HEDIS 2013 Medicaid 25th percentile, and five were above the national 50th percentile. Nonetheless, no rates met the MQD Quality Strategy targets. There is much room for 'Ohana to improve rates for all of these measures in future HEDIS reporting years.

QExA

Four rates ranked below the national HEDIS 2013 Medicaid 50th percentile, with one of them ranking below the 25th percentile. These rates, and two additional rates under *Comprehensive Diabetes Care*, presented opportunities for improvement.

CCS Readiness Review

'Ohana was able to report valid rates for 11 of the 16 rates, with five rates receiving an audit result of *NA* due to a small denominator. Of the 10 rates with available HEDIS benchmarks for comparison, five rates ranked below the national 50th percentile. While 'Ohana should focus on improving the CCS rates that were below the national 50th percentile, its HEDIS 2014 rates will also serve as baseline performance for future reporting years.

Improvement Activities Implemented:

'Ohana's Quality Improvement Intervention Workgroup (QIIW) and Quality Improvement (QI) Team HEDIS Focus Workgroup met regularly to review performances of HEDIS measures, complete causal barrier analysis, and monitor status updates of interventions developed specifically to improve HEDIS rates. Smaller workgroups were also developed to address specific HEDIS measures, such as behavioral health and child-related measures. The following are improvement activities that were continued or implemented in 2014:

- 'Ohana continued to receive lab results directly from lab vendors – Clinical Laboratories and Diagnostic Laboratory Services. In addition, providers who performed their own blood tests in-house (not at a diagnostic laboratory) were identified through claims data. During the quality-focused provider visits, the QI staff discussed the importance of receiving lab results from the provider and retrieved appropriate medical records. These medical records were reviewed and data entered into an auditor-approved supplemental database.
- HEDIS practice advisors (HPAs) were hired to conduct quality-focused provider visits. In partnership with the Provider Relations representatives, providers received education and coaching on HEDIS measures, as well as resources in improving HEDIS rates, including HEDIS tool kits, Preventive Care Checklist, and care gap reports. In addition, providers received education on the HEDIS On-line Tool (via provider portal) as an additional method to look up members' care gaps and close HEDIS gaps in care by submitting medical records

through the online tool. Information on the Disease Management program and instructions on how to refer a member to the program were also provided. 'Ohana's medical director attended some of these provider visits to assist with provider education.

- Pay-for-Performance bonus program was offered to the top volume providers.
- 'Ohana partnered with a mobile provider, FirstVitals to complete retinal eye screenings within health centers and PCP offices.
- 'Ohana continued to insource the process of scheduling and retrieving of medical records. Thirty temporary staff members were on-boarded to schedule and retrieve records. This resulted in an increase of approximately 15 percent more records retrieved as compared to 'Ohana's previous vendor, Outcomes, who managed medical record retrieval.
- Chronic condition and preventive screening articles for both member and provider newsletters were published. Also, periodicity letters were mailed to members to remind them of preventive screenings and the importance of seeing their PCP.
- Community Case Management Agencies (CCMAs) were provided care gaps reports, and a scorecard was developed to monitor the CCMA's progress in closing care gaps. In addition, 'Ohana partnered with Clinical Laboratory to provide fecal occult blood test (FOBT) kits. These FOBT kits were distributed to the Community Case Management Agencies (CCMAs). The CCMA hand-delivered the kits to their foster home caregivers to complete the FOBT for the members with colon cancer screening care gaps.
- Several outreach programs to educate members on chronic condition management and preventive screenings were completed. The following lists 'Ohana's various outreach programs:
  - Centralized Telephonic Outreach program consisted of a vendor (Results) conducting calls to members with HEDIS care gaps and assisting with scheduling an appointment with their physician (PCP) and arranging transportation when needed.
  - The EPSDT coordinator outreached parents and guardians of pediatric members to educate and assist with scheduling appointments for well visits and to get their immunizations updated.
  - The service coordinators (SCs) addressed care gaps with members during their home visits or follow-up phone calls. In addition, one designated service coordinator focused on outreaching members discharged from a mental health facility to close care gaps.
  - An After Hospitalization Outreach Program was implemented, which consisted of the Disease Management nurse following up on members who were discharged from the hospital and who had a diagnosis of congestive heart failure (CHF), diabetes, coronary artery disease (CAD), or asthma. The nurse called members within 48 hours from discharge, provided medical condition and medication education, and assisted with scheduling a follow-up with PCP.
- A Preventive Care Checklist which incorporated HEDIS-related tests and procedures was implemented and distributed to intermediate care facility (ICF) level of care members. The reader-friendly checklist doubles as an educational tool explaining in simple layman's terms the "why" behind the age-specific, gender-specific, and disease-specific tests and procedures on the list. The SCs/DM RNs discussed the checklist with members and instructed them to bring the checklist to the doctor's office during a follow-up visit for completion.

'Ohana's Disease Management (DM) program educated members about their disease, setting disease-specific target goals, and improving members' self-management skills, all which will

positively impact members' health outcomes and increase compliance with chronic conditions HEDIS measures. The importance of preventive visits and timely tests/screenings were addressed during each member contact. As needed, the DM nurses reached out to the treating providers to assist with scheduling a follow-up visit. A post hospital discharge management program (AHOP = After Hospital Outreach Program) has been added as a subprogram under DM with the goal of reducing 30-day readmission of members with discharge diagnosis of heart failure, diabetes, asthma or CAD. AHOP's interventions include improving members' understanding of their medical condition, medications, post discharge instructions, as well as importance of timely follow-up visits with their PCP/specialists.

Specifically for CCS members, 'Ohana worked with other health plans to receive file information for HEDIS measures that are based on medical services. The Behavioral Health (BH) Case Management agencies received education on the different HEDIS measures. The Inpatient Notification form, which is used to notify BH Case Managers of an admission to the hospital, was modified to include a section for follow-up after hospitalization (FUH) appointments.

In addition, for CCS members, 'Ohana collected behavioral health assessments from CCS Behavioral Health Case Management agencies. A focused CCS BH Case Management agency meeting was held to educate the case management agencies on the HEDIS measures. As a follow-up, 'Ohana hosted a detox in-service for CCS BH Case Management agencies to help the agencies understand their options in helping members close care gaps for the *Initiation and Engagement of Alcohol and Other Drug Abuse Treatment* (IET) measure.

'Ohana QI staff met with hospitals to discuss readmissions, as related to the *Plan All-Cause Readmissions* (PCR) HEDIS measure and educated on the importance of scheduling a follow-up appointment for members, as related to the FUH and IET HEDIS measures.

UnitedHealthcare Community Plan

UHC CP's HEDIS Performance Measures Recommendations

QUEST

UHC CP reported valid rates for 16 of the measures with the other 20 having an audit result of *NA* because of small denominators. Of the 16 valid rates, nine ranked below the national HEDIS 2013 Medicaid 25th percentile. One ranked above the 75th percentile and met the MQD Quality Strategy target. UHC CP should focus on improving the measures with low rates, particularly the *Well-Child Visits in the First 15 Months of Life* measure and the HbA1c, blood pressure, and LDL-C control indicators under *Comprehensive Diabetes Care*.

QExA

Of the 18 rates with available benchmarks for comparison, three rates ranked below the national 50th percentile, two of which were below the national 25th percentile. These three rates, all related to blood pressure control, presented opportunities for improvement for UHC CP.

Improvement Activities Implemented:

The Quality Improvement (QI) Program describes the coordinated and collaborative activities and initiatives of UHC CP to provide the services necessary to meet the needs of its members and to continuously improve physical and behavioral healthcare outcomes. To meet the needs of members with multiple healthcare needs, UHC CP utilizes an integrated care model employing systematic coordination of physical, pharmacy, and behavioral healthcare integrating mental health, substance abuse, and primary care service management to produce better outcomes.

Well-Child Visits in the First 15 Months of Life

Status: Implemented and ongoing

EPSDT education was provided at health fairs by registered nurses to educate members about the importance of completing all well-child visits within the appropriate time frames. This will ensure identification of potential health problems and provide early intervention. Members who did not complete their well-child visits were contacted via phone calls and letters to encourage them to complete their well-child visits with their primary care providers (PCPs) and to develop a positive relationship and continued engagement with the healthcare system. EPSDT reports were delivered to providers to identify members who were in need of a well-child visit. In mid-2014, UHC CP launched the Clinical Practice Consultants (CPC) program, where the CPCs worked with the providers and office staffs to provide education and to develop processes, workflows, and tools to assist the PCP to re-engage these members.

UHC CP activities included coordination of internal Marketing, Quality, and Provider Network departments to identify member and PCPs to target interventions to improve completion of well-child visits in the first 15 months of life.

CDC/CBP Measure Improvement Initiatives

Status: Implemented and ongoing

Additional clinical practice consultants were added to the Quality staff to focus on provider quality performance interventions. Additional provider network advocates were also added to improve assistance and training of providers. Quality Team members were added to focus on quality performance improvement. Trainings were provided to service coordinators to address HEDIS gaps in care. Trainings on quality performance measures were provided to all staff to promote quality within the organization's culture.

CDC and CBP Measure Improvement Initiatives—Disease Management

Members with diabetes were identified and were enrolled in the UHC CP's Disease Management Program. Disease management members were regularly sent materials on diabetes disease management which included education around blood pressure control. Articles on diabetes and diabetic kidney disease, and class schedules for diabetes, preventive healthcare, and disease management were released in 2014 and 2015 through the UHC CP Member HealthTalk newsletter. Providers were educated on HEDIS requirements and clinical practice guidelines semiannually. UHC CP organized and held the first Hawaii Provider Quality Conference in February 2014 and again in May 2015 where primary care providers were educated on HEDIS and important updates. The CPC program was implemented in mid-2014; CPCs provided education for the providers and their office staff around HEDIS (including CDC and CBP requirements) and information on the health plan's available support services. UHC CP also implemented the Accountable Care Communities program to improve on the utilization and quality metrics.

As a result of member, provider, and health plan interventions, all but one of the CDC submeasures in the QExA plan showed an increase in HEDIS 2015 and rated above the 2014 NCQA 50th percentile. The CDC HbA1c < 7% for a selected population decreased but remained above the 2014 NCQA 50th percentile.

The QUEST plan also showed increases in its CDC BP < 140/90 and *Controlling High Blood Pressure* (CBP) measures. However, the CDC BP <140/90 measure continued to be below the 2014 NCQA 25th percentile. The health plan will continue to work on improving the CDC measure, especially the submeasures that are below the 25th percentile. (Note that the CDC BP <140/80 and LDL-C < 100 measures were retired in HEDIS 2015.)

2014 Validation of Performance Improvement Projects

AlohaCare

AlohaCare's Performance Improvement Projects Recommendations

The Outcomes stage represented an area for PIP improvement, as not all study indicators demonstrated improvement.

HSAG recommended the following:

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

Improvement Activities Implemented:

AlohaCare received notification of the rapid-cycle methodology for 2015 PIPs and the training schedule of modules 1–5. This was an entirely new methodology with accountability, and each module had to be passed in order to proceed to the next. HSAG provided technical support as the plan learned this new method. This method required the involvement of other disciplines that were both internal and external to the plan.

AlohaCare has passed modules 1, 2, and 3, and training for modules 4 and5 was received on July 28, 2015.

HMSA

HMSA's Performance Improvement Projects Recommendations

The Outcomes stage represented an area for PIP improvement as not all study indicators demonstrated improvement.

HSAG recommends the following:

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

Improvement Activities Implemented:

HMSA followed continuous quality improvement (CQI) Plan, Do, Study, Act practices in the development and implementation of its strategies. On a regular basis HMSA evaluated intervention efficacy and conducted causal/barrier analysis. As a result, interventions could be discontinued, revised, or new interventions implemented as needed throughout the year.

In July 2014, HMSA resubmitted the recalculated denominator as recommended in the *Point of Clarification*.

Kaiser

Kaiser's Performance Improvement Projects Recommendations

The Outcomes stage represented an area for improvement in the *All-Cause Readmissions* PIP, as the study indicator did not demonstrate improvement.

HSAG recommends the following:

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

Improvement Activities Implemented:

Kaiser identified the following SMART Aim as part of the 2015 PIP: Reduce readmission rate of QUEST Integration members hospitalized at Kaiser Foundation Hospital-Moanalua for all ages who do not meet the exclusion criteria from 13.2 percent to 12.7 percent by June 30, 2016.

To address the 2015 Readmissions PIP Kaiser (1) identified the key drivers and interventions, (2) developed the data collection process, and (3) determined failures that warrant quality improvement. See below for a summary on each of the three phases.

I. Key Drivers and Interventions

Key Drivers:

1. Discharge Instructions/Education
2. Patient Barriers
3. Follow-up/Access
4. Care coordination between inpatient and outpatient
5. Medications

Interventions:

1. Service coordinators to perform a two-business day post discharge telephone call to assess patient, clarify discharge instructions, remind or make follow-up appointment, identify patients requiring home visit, earlier clinic appointments, or other care coordination.

2. Service coordinators will assist members to eliminate barriers to keeping appointments; for example arrange transportation for clinic visits and/or arrange home care nurse visits.
3. Schedule appointment for post-hospital follow-up appointment with PCP or specialty clinic.
4. Social workers will support service coordinators for members with social barriers.
5. Standardized discharge summaries with clear instructions to the outpatient team about follow-up.
6. Transitional care pharmacists to do bedside medication reconciliation and education pre-discharge.
7. Clinic-based pharmacist to do medication reconciliation and education post-discharge.

II. Data Collection Process

1. On the first business day of each month, the supervisor of Quality Management Consulting and Analysis will run a report in Clarity to generate a list of eligible QUEST Integration members readmitted to Kaiser Foundation Hospital within 30 days of discharge. An Excel spreadsheet with a list of QUEST Integration members readmitted to Kaiser Foundation Hospital within the last 30 days will be sent via encrypted email to the Readmission Performance Improvement Plan (PIP) Team members. The Readmission PIP team will evaluate this list monthly.
2. The rate calculation will be performed using the Excel spreadsheet formula division function and the result will be that month's percentage of eligible QUEST Integration members readmitted to Kaiser Foundation Hospital- Moanalua within 30 days of discharge.
3. Kaiser selected a conservative SMART Aim goal to reduce the readmission rate from 13.2 percent to 12.7 percent. The readmission SMART Aim will reach meaningful improvement when six out of eight consecutive data points are trending toward the goal.

III. Intervention Determination

Kaiser has developed a high-level process map from the perspective of the customer that captures where breakdowns in the process may occur that would affect hospital readmissions. From this map three sub-processes were selected that had the most potential to make the greatest impact. Failure modes, causes, effects and priorities were also identified for each sub-process. Based on these results the failures modes were ranked from the highest priority to the lowest and the failure modes that warranted quality improvement were identified. The result of this analysis is the final Intervention Determination captured below.

Intervention Determination		
Failures	**Potential Interventions**	**Consideration for Reliability**
Patient doesn't answer call or return messages	Chart review will include: review of reason for admission to assess for risk of readmission. Check if discharge medications were picked up; confirm patient attended hospital follow-up appointment. If patient missed appointment, chart review will be performed to assess via triage criteria if service coordinator should perform visit to member's home.	Chart review will identify patients at higher risk for readmission. If service coordinator performs home visit, barriers to patient's post hospital recovery may be identified and this process may decrease readmissions.
Patient doesn't understand discharge medication instructions	Discharge medication instructions and comprehensive medication review will occur during post discharge follow-up telephone call. Medication reconciliation will be performed to reduce duplicate medications.	Medication reconciliation will decrease duplicate medications and unnecessary medications. Medication review will increase the likelihood of compliance with discharge medication regimen.

'Ohana

'Ohana's Performance Improvement Projects Recommendations

QUEST

There were no recommendations. Both PIPs received a 100 percent—*Met* validation status.

QExA

There were no recommendations. Both PIPs received a 100 percent—*Met* validation status.

CCS

There were no recommendations for improvement in this year's validation.

Improvement Activities Implemented

Not applicable/no response required.

UnitedHealthcare Community Plan

UHC CP's Performance Improvement Projects Recommendations

QUEST

HSAG recommended the following:

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

QExA

HSAG recommended the following:

- For the *Diabetes Care* PIP, the health plan should correct the *p* value for Study Indicator 2 from baseline to the first remeasurement.
- For the *Diabetes Care* PIP, the improvement was not statistically significant for either study indicator. UHC CP should implement strategies to improve performance. The health plan should regularly evaluate interventions to ensure that they are having the desired effects. If the health plan's evaluation of interventions and/or review of data indicates that the interventions are not having the desired effect, the health plan should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions, as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.
- For the *BMI* PIP, the health plan should ensure that all percentage point differences between measurement periods and Chi-square test results are reported accurately and consistently throughout the PIP Summary Form.
- With its *successful* and sustained improvement on this PIP, UHC CP may want to consider it for retirement, with approval from the MQD to do so.

Improvement Activities Implemented:

The above PIP feedback was addressed in the final 2014 PIP submission in August 2014.

- For the *All-Cause Readmissions* PIP, the resubmission still included "Observed to Expected Ratio" in the study indicator title. The health plan removed this in the final submission.
- For the *Diabetes Care* PIP, the health plan corrected the interpretation for Study Indicator 2 to state the correct goal.
- For the *Diabetes Care* PIP, the health plan corrected the *p* value for Study Indicator 2 from baseline to the first remeasurement.
- The *BMI* PIP, with its successful and sustained improvement, has been retired.

Previous PIP methodologies were retired and replaced with the Rapid-Cycle Improvement process as trained by HSAG. Diabetes has been reselected for the new PIP rapid-cycle improvement process. Through the new PIP rapid-cycle improvement process, the health plan has revisited the causal/barrier analysis process, verified that the proper barriers are being addressed, and are reviewing new interventions. Processes will be revisited as often as needed during the duration of the PIP.

2014 Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey

AlohaCare

AlohaCare's CAHPS Adult Survey Recommendations

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

Improvement Activities Implemented:

Getting Needed Care/Getting Care Quickly

In the first quarter of 2015, an annual assessment was completed on the Accessibility of Providers.

1. **Surveys**

   a. Member and Provider appointment survey

      A comparison of the survey results indicates disparities between member and provider perception of compliance with appointment standards.

   b. Behavioral Health Care Practitioners Survey

      The appointment standards for behavioral health routine, behavioral health urgent, and behavioral health non-life-threatening emergency were not met. The acceptable time standard for AlohaCare's appointment requests is 90 percent.

      Based on these surveys, AlohaCare is:

      - Is evaluating ways to mitigate survey respondent bias to reduce inaccuracies.
      - Has eliminated the prior authorization and referral requirement for providers who are located in rural areas in the State of Hawaii to alleviate some the administrative burden on providers. In addition, AlohaCare conducted targeted recruitment of new providers, specialized arrangements to attract certain providers, and offered care coordination and management for members.

   c. After-hours access to care surveys

      50 percent of providers that were surveyed had a system in place for members to contact the provider afterhours. Sixty-five percent of providers that were surveyed had a system in place for providing directions to obtain emergency services, and only 45 percent of providers that were surveyed had a system in place for directing members on how to obtain urgent medical care.

      Based on this survey, AlohaCare is:

      - Informing and educating providers about the requirement for after-hours access to care and providing examples of best practices for after-hours, out-going phone greetings and messages.

d. Member grievances were reviewed and there were no member grievances related to appointment timeliness and behavioral health appointment timeliness.

Community Relation Events

The plan's Community Relations Department has been hosting community events throughout the island of Oahu with the goal of facilitating better care, healthcare education, and connecting the community with much-needed resources. These events are geared toward making members aware of healthcare resources in the community.

Community Event Focus

- Free Dental Services
- Healthcare Educational Services
- Medicare and/or Medicaid Educational Services
- Community Health Center Services
- Homeless Shelter Services

AlohaCare is also:

- Partnering with social service agencies to facilitate better care for members in need of services.
- Building better partnerships with Community Health Centers to facilitate better member compliance, medication adherence, and faster access to care for members.
- Continuing to grow and enhance member events to cover the full spectrum of services.
- Emphasizing member needs programs. This includes partnerships and events on Maui, Kauai, and the Big Island.

Member Communications

All members received an updated member handbook in 2015 that provided information on when to see a PCP versus going to urgent care or the emergency room.

Members were mailed a notification in March 2015, updating them about resources available on the plan's website.

- The website contained health and wellness information that may be pertinent to many members, and included health education and preventive healthcare information.

The plan also posted health tips and links to healthy recipes on its social media accounts and will be increasing this type of content in 2015 and beyond.

Provider Communications

AlohaCare resumed its quarterly distribution of provider newsletters to all providers in 2015. Topics included access and availability standards as defined by the State, as well as instructions for after-hours call best practices. Topics relevant to getting needed care and getting care quickly are slated for the remaining issues in 2015 and future 2016 issues.

Customer Service

Call Center

AlohaCare call center hours were from 7:45 a.m.–8 p.m. Monday–Friday. AlohaCare after-hours phone coverage was from 8 p.m.–7:45 a.m. Monday–Friday, weekends and holidays. The after-hours phone service can respond to eligibility questions for members and providers. If further assistance is needed, the after-hours phone service will call AlohaCare after-hours to assist with travel, authorizations, and all other emergent issues that are not able to wait until the next day**.**

Training Program

Customer Service staff went through a three-week training program once hired. The training program consisted of system knowledge, benefit training, phone skills, and conflict resolution. There was also a supervisor on the floor in the call center to assist with all escalated issues. Customer Service staff had weekly meetings to go over refresher trainings and conducted grievance/appeals training annually.

Performance Measures

Customer Service had required measurements. Reports were generated and results were tracked and reported to staff members monthly.

HMSA

HMSA's CAHPS Adult Survey Recommendations

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

Improvement Activities Implemented:

Customer Service

HMSA's call center hours were Monday through Friday from 7:45 a.m.–4:30 p.m., and walk-in service at an HMSA Neighborhood Center was available Monday through Friday from 8:00 a.m.–6 p.m. and Saturday from 9:00 a.m.–2:00 p.m. After-hours call center servicing could assist with eligibility inquiries, finding a participating specialist, or nonemergent transportation and accommodations. All other inquiries were forwarded the next business day to normal hours servicing staff that followed up with the member or provider.

All HMSA call center representatives were required to attend the Ulysses Training program which focuses on achieving greater call control in order to provide an optimal experience for members and providers, while consistently meeting call handling guidelines. Highlights of the Ulysses training include greeting the caller in a professional manner, acknowledging the caller's issue and emotion, asking member permission before asking questions, identifying concerns by asking questions regarding the situation or issues to validate inquiries, assisting the caller by providing solutions with options to gain acceptance, recapping and providing next steps to resolution, and ending each call by asking if there is anything else the servicing staff can do to help.

In addition to the formal Ulysses training, HMSA conducted biweekly call center representative training, covering topics brought up by staff or identified by leadership based on recorded/live call monitoring. One-on-one coaching was also done as needed.

To address performance, call center representatives had daily unit huddles, weekly call audits which identified potential issues or gaps as well as provide positive feedback, and side-by-side coaching.

Getting Care Quickly

The HMSA value-driven healthcare initiative consists of a Patient-Centered Medical Home (PCMH) provider program and a pay-for-quality program. One of the expectations of PCMH PCPs is that they work to improve care coordination and can demonstrate this by implementing open scheduling, and providing additional ways for members to access a care team through telephone, secure electronic messaging, or other means.

Cozeva is a web-based platform that promotes communication between providers and their HMSA members/patients. It identifies gaps in care and sends reminders to members in preferred formats (e.g., email, phone, or text). Cozeva allows members to communicate electronically with their PCP,

make appointments, receive individualized reminders, request prescription refills, and access their medical records.

HMSA provided a 24-Hour Nurse Advice Line that members could call to talk with a nurse, ask medical questions, and obtain guidance regarding whether the member should see a doctor or go to the emergency room. HMSA's 24-Hour Nurse Advice Line could also refer a member to a participating provider.

For members that were chronic no-shows, providers had the option of referring the member for service coordination. The service coordinator assigned to the member would assist with identifying barriers, developing a service plan, and coordinating services that would support the member's needs and reduce no-shows.

Getting Needed Care

HMSA promoted its "living life to the fullest" program with healthy lifestyle habits through health education workshops. These workshops used interactive methods to teach fitness, nutrition, stress management, and other aspects of health and well-being that could impact physical, emotional, and social health. The workshops were engaging and designed with varying learning formats and levels of participation from a scale of low, medium, and high. Workshops were offered throughout the year at no cost.

To simplify and streamline the referral process and to ensure members have access to care when they need it, HMSA revised its referral process for specialty care. Beginning in January 2015, PCPs only need to register referrals with HMSA for off-island specialty care, referrals to nonparticipating providers, plastic surgery, rehabilitation services, and dermatology services. Although a registered referral was no longer required, PCPs and specialists must still keep records of referrals in their patient's record.

Rating of Specialist Seen Most Often

The plan has been conducting skills training for specialists over the past several months which included a specialized workshop focusing on cultural competency to facilitate and improve physician-patient communication. The workshop included:

- Cultural background and values shape member views.
- Members have a right to be treated with courtesy, consideration, and respect.
- Respect diversity and eliminate biases and preconceptions that can be barriers to successful delivery of health services.
- Provider foreign language capabilities.
- Outreach and care assistance to members should be sensitive to their beliefs but aimed at improving their health outcomes.
- Debunking myths about public assistance members (e.g., they are all noncompliant, providers have to make all healthcare decisions, those with disabilities are incapable of discussing their own health).

As part of HMSA's strategy to improve CAHPS results, multiple member-focused communications were implemented over the past year aimed at improving the provider-patient relationship and increasing member engagement in their care.

CAHPS Composite	Communication	Description
Getting Care Quickly Getting Needed Care	Island Scene Article (Winter 2014) – "Work With your Doctor"	This article provided members with information regarding making the most of their doctor visit, "give and take" in scheduling/appointment expectations, and the importance of having a relationship with one physician to enhance access to care
	Island Scene Article (Winter 2014) – "Need Some Medical Care?"	This article provided members with information about the CVS Minute Clinic (walk-in clinic) available at select locations as an alternative access to care
	Island Scene Article (Winter 2014) – "Helping You Make Wise Choices"	This article encouraged members to take an active role in their healthcare and provided a checklist to prepare for and make the most of their doctor visit
Getting Care Quickly Getting Needed Care	QUEST Integration Member Newsletter (August 2014) – "Make Your Doctor Visits Count"	This article provided information on making the most of the doctor visit
	QUEST Integration Member Newsletter (August 2014) – "Find The Perfect PCP for Good Health"	This article reinforced the importance of a good relationship with the member's PCP
	QUEST Integration Member Newsletter (March 2015) – "Getting Care From Your PCP"	This article discussed general wait times in appointment scheduling and expectations/time frames
	QUEST Integration Member Newsletter (July 2015) – "Partner With Your Primary Care Provider for Good Health"	This article reinforced the importance of a good relationship with the member's PCP

Kaiser

Kaiser's CAHPS Adult Survey Recommendations

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

Improvement Activities Implemented:

Rating of Specialist Seen Most Often

Kaiser members were provided access to online tools that make communication with their providers easy and at the member's convenience. Communication tools included email, the ability to check test results, send pictures to their specialists, make appointments online, etc. QUEST Integration service coordinators and customer service representatives also reinforced access to these tools when communicating with members.

Annual cultural competency training was delivered to all Kaiser medical staff. The Affiliated Care manual sent to each provider also included Kaiser's Cultural Competency plan, and providers were credentialed every 24 months which included a cultural competency review.

Kaiser had a standardized process in place that prompted follow-up with members who had upcoming appointments to ensure all key activities were completed prior to their appointment. Members also received a patient satisfaction survey after their visits and feedback was delivered to physicians based on member responses.

Lastly, Kaiser is working with MQD to understand the guidelines on leveraging telemedicine.

Getting Needed Care

"Max-packing" is one of several strategies which Kaiser used especially for noncompliant patients or those with transportation needs. Kaiser was able to consolidate appointments around a member's transportation availability (i.e., when the member had someone who could drive them), and meet with the member face-to-face while the member was at one location for multiple appointments.

Kaiser's Health Education Department offered a variety of classes to members in both individual and group settings (e.g., diabetes and chronic kidney disease). Class offerings were posted online and also printed and available at each Kaiser clinic. Kaiser's Patient Support Services team was also actively focused and engaged with members on care management.

As mentioned above, Kaiser members had access to online tools that helped make getting needed care easier. Communication tools included email, the ability to check test results, send pictures to their specialists, refilling prescriptions, make same-day appointments online, etc. Kaiser members could also call and speak with a nurse or physician assistant at any time.

Kaiser also used an electronic referral system and a standardized referral form.

Getting Care Quickly

A no-show appointment follow-up process was implemented at each of the Kaiser clinics. Additionally, the QUEST Integration service coordinators followed up with high-risk, no-show patients and utilized other strategies to facilitate a member's appointment compliance, including but not limited to checking for future appointments with different providers and meeting the member at the appointment, conducting home visits, analyzing and working with the members on barriers identified, etc.

As mentioned above Kaiser members were provided access to online tools that made getting care quickly easier. Communication tools included email, the ability to check test results, send pictures to their specialists, refilling prescriptions, make same-day appointments online, etc.

Patient flow analysis was performed on an as needed basis at the Kaiser clinics and results were analyzed to identify areas for improvement. In 2014 Kaiser focused heavily on improving access to same-day appointments by performing extensive data analysis, increasing staffing, and standardizing processes to ensure appropriate availability and coverage.

Kaiser clinics and call centers also utilized a standard triage process to ensure members received the right care quickly.

'Ohana

'Ohana's CAHPS Adult Survey Recommendations

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

Improvement Activities Implemented

Appropriate Healthcare Providers

'Ohana does not require a PCP to obtain authorization for a referral to an in-network specialist. This eliminates the time it takes to process an authorization for a specialty referral and allows the member to access care in a timely manner. Customer service representatives also assisted members in accessing care by helping members through the "find a provider tool" available via the 'Ohana Web portal. If a member was unsuccessful using the online tool to locate a provider, local customer service representatives partnered with Provider Relations to support ensuring the member had access to the needed care in the nearest most appropriate clinical setting. 'Ohana's EPSDT coordinator also followed up on referrals documented on the EPSDT forms to ensure pediatric members follow through on referrals made by their PCP.

Interactive Workshops

'Ohana conducted 10 education sessions per month across Oahu, Maui, Hawaii, and Kauai. In addition, 'Ohana participated in and provided health educational information sessions at 11 major events on Oahu, 16 in Maui County (all islands), five on Kauai, and 10 on the Big Island for a total of 42 events during 2015. This gave the plan an opportunity to discuss important health topics including chronic conditions, women's health, and children's health.

'Ohana recognized that educating members about their disease, setting disease-specific target goals and improving member's self-management skills positively impacted their health outcomes. Its Disease Management (DM) program continued to put focus on high member engagement during health coaching sessions and use member-driven goals to measure progress. The importance of preventive visits and timely tests/screenings were addressed during each member contact.

Members who had special healthcare needs or need long-term services and supports were assigned a service coordinator. The service coordinator performed a home visit and completed a health and functional assessment. During the assessment, service coordinators asked disease-specific questions related to asthma, cancer, diabetes, end-stage renal disease, heart disease, hepatitis B/C, high blood pressure, HIV/AIDS, seizures, and shortness of breath. A service plan was developed to address identified problems and interventions. Service coordinators also educated members with chronic conditions on the availability of the DM program. If members declined enrollment in DM, service

coordinators offered to provide members with educational materials about their health condition and the recommended tests/procedures needed per chronic condition.

"Max-Packing"

The HEDIS practice advisors and Provider Relations representatives distributed HEDIS tool kits to providers, which included a Personal Preventive Care Checklist. Providers were encouraged to use this checklist for each patient. The list included screenings for preventive care and chronic condition management and the last date the screenings were performed. It served as a reminder for the providers of which screenings were due for the patient in order to help them maximize each patient office visit. In addition, the plan assisted providers with updating their EMR tickler system to include the appropriate screenings and due dates. This tickler system flagged the provider during the patient's office visit of any required screenings.

Referral Process

To promote quick and timely access to care for members, 'Ohana does not require a referral to an in-network specialist. In the event providers did provide a referral to another provider, 'Ohana had a number of ways to assist the member in getting in to see a specialist.

Customer service representatives (CSRs) assisted members by using an internal provider directory to locate participating specialists. CSRs also advised members on how to locate the specialist directory on the 'Ohana website located at www.ohanahealthplan.com. When members were looking only for contact information on a provider, a CSR offered to call provider offices and verify that the provider would schedule an appointment with the member. The following additional scripting was added for HI members in the PCP Change work flow, "If you are receiving care from a specialist it is essential that you let your new primary care doctor know so that he/she can coordinate your care. You receive the best care when your doctors talk to each other. You can help by asking each of your doctors to complete a consent form. If you have any questions please speak with your doctor or call Customer Service at the number on the back of your ID card."

In instances when members advised that they had been unable to locate a specialist, a member issues template was completed that included all pertinent case information and emailed to Service Coordination. It was then processed in conjunction with Provider Relations in an attempt to either locate a participating specialist or develop a contract agreement for the member to visit a nonparticipating provider.

'Ohana's EPSDT coordinator reviewed EPSDT forms for any referrals marked by the PCP and conducted outreach to those members. The EPSDT coordinator assisted members with scheduling an appointment with a specialist or therapist by placing a three-way call to the provider. Upon request from the specialist or therapist, the EPSDT coordinator faxed the EPSDT form to the provider to demonstrate the PCP made the referral.

Decreasing No-Shows Appointments

'Ohana worked with its transportation vendor to ensure members were picked up and taken to their appointments on a timely basis. The Service Coordination Triage Team worked collaboratively with

Customer Service to locate specialists for members, based on member needs and provider choice. Periodically, 'Ohana received unique or unusual requests from members or PCPs for specialists. These requests resulted in the plan's Triage Team contacting the PCP for clarification or assigning a field service coordinator to do a home visit and communicate with the PCP to determine the specialists and other provider needs of the member.

Electronic Communication

'Ohana and its provider community understand and appreciate the value of electronic communications. One of their network's largest lab vendors has begun offering online access to lab test results, which members can access at their convenience. 'Ohana was in the process of working with other lab vendors to offer this same service. The plan ran monthly reports to identify new pregnant members and mailed them a flyer informing them of the Text-4-Baby national program in which a pregnant woman may receive important health information and reminders via text on their phones.

Open Access Scheduling

Some 'Ohana providers have begun adopting an open access scheduling model. One provider in particular discovered this model has worked to decrease his members' ER utilization. 'Ohana has shared this information with other providers to encourage other providers to implement the model.

Patient Flow Analysis

'Ohana utilized provider newsletters to educate its network on the importance of reducing wait times to increase patient satisfaction.

Alternatives to One-on-One Visits

'Ohana has partnered with First Vitals to bring retinal screening into PCP offices and on-site within the health clinics on a regular basis. This screening allowed members to get their diabetic retinal screening while seeing their PCP during the same office visit (max-packing). If the findings of the retinal screening showed an abnormality, the PCP was able to follow through and ensure the member scheduled an appointment with an eye care professional for more thorough care.

As previously discussed, one of 'Ohana's network's largest lab vendors has begun providing online access to lab test results, which members could access at their convenience. Other lab vendors were in the process of allowing the same capability. This helps alleviate the need for members to have an appointment with their doctor to receive lab test results, unless necessary. 'Ohana has also educated providers on the advantages of telemedicine via provider newsletter articles.

Health Plan Operations

'Ohana considers the provider network as part of its microsystem. For example, 'Ohana's Utilization Medical Advisory Committee (UMAC) engaged in processes with physician attendance and reviewing and monitoring of processes and data, making recommendations, as needed. The plan also held regular manager meetings and meetings with senior leadership in which functional

operations were discussed and workgroups were created when needed to further analyze an issue or concern.

Promote Quality Improvement Initiatives

Quality remains at the top of ‘Ohana’s goals. The plan understands the importance of organization-wide engagement in an effort to improve the quality care members receive. The quality theme was carried forth in the plan’s Quality Improvement Interventions Workgroup in which representation of all functional departments met, and discussed and tracked progress on key quality initiatives. In addition, the Quality Department continued to provide quality-focused education (HEDIS, CAHPS, quality of care, etc.) in functional team meetings. The intent was to emphasize each person’s importance in contributing and improving the plan’s quality performance. In addition, quality was highlighted and educated upon during each new hire’s onboard orientation training.

Access to Care

Access to care was monitored through quarterly telephonic surveys that were focused on timely accessibility of appointments for members. Both members and providers were surveyed interchangeably. When survey results identified a provider or practice as not meeting accessibility and availability standards, a Provider Relations representatives conducted outreach to educate the provider on the contractually required accessibility of timely appointments. Providers not meeting the requirements may be required to produce a corrective action plan showing how and when improvement will be demonstrated.

‘Ohana’s Value Based Purchasing Program was designed to foster access to care and coordination. One part of the program rewarded providers who attained NCQA PCMH recognition via a capitated per member per month (pmpm) payment. Open panel providers who were willing to accept new ‘Ohana members received an enhanced PCMH pmpm payment.

In addition, the plan also monitored access to care via quarterly GeoAccess reports. The plan tracked the distribution of participating providers by geographic region and measured them in relation to the number of members in particular region. Access was measured by the drive time to the appointment. ‘Ohana used that information to identify regions that may be deemed a high priority for network enhancement opportunities. A network management specialist identified if there were any non-par providers in those regions and reached out to determine a provider’s willingness to contract with ‘Ohana.

Patient and Family Engagement Advisory Councils

‘Ohana recognizes the importance of first-hand feedback on members experience with the health plan and its provider system from ‘Ohana’s members directly. For this reason, it established the Members Matter Advisory Committee (MMAC). This committee is composed of ‘Ohana members and key ‘Ohana management staff representing various functional business areas. The Committee’s first meeting was held mid-year in 2014 and it continued on a quarterly basis. It has a total of four members who are official committee members, and the plan did continual outreach to include more members. An article in the member newsletter informed and encouraged members about the committee and invited them to join, as committee member. All ‘Ohana members interested in

sharing their feedback with the plan can do so in an effort to help improve their experience with the plan. The MMAC committee meetings have been beneficial in helping ‘Ohana identify areas of improvement.

Call Centers

‘Ohana continued to monitor call volumes and hours of operation and have determined its call center is open during appropriate hours of operation based on customer needs. The call center was appropriately staffed to ensure calls were answered promptly. Currently the phone system is set up to ask customers if they would like to complete a survey following their call. All survey responses continued to be reviewed for possible areas of improvement.

The Call Center Department was divided into three separate teams. One team handled provider only calls, a second team handled member only, and the third team was a hybrid team that serviced both member and provider calls. The teams were divided in an effort to develop subject matter experts (SMEs) for each call type and have calls evenly distributed throughout the call center. There were two designated customer service representatives (CSRs) dedicated to monitoring inbound call queues to ensure the plan was appropriately staffed to take both member and provider calls. CSRs were reskilled as necessary to absorb an influx of calls on either queue.

Creating Effective Customer Service Training Program

In an effort to ensure new hires were adequately equipped to address member concerns, each new representative underwent six weeks of new hire classroom training. Training was conducted by a dedicated customer service (CS) training specialist. Training modules covered everything from soft skills and effective communication tools, to HIPAA, cultural competency, Medicaid, and Medicare. Periodic refresher training was conducted to ensure that all CSRs were up to speed on any and all new processes and workflows. This helped to ensure they were also aware of all resources available to them to provide customers with an exceptional customer service experience.

The Step Up Program was deployed to assist new CSRs with the transition from the training environment to the production floor. The Step Up Program was designed to supply CSRs who just finished training with a controlled environment in which they could begin to take live calls. CSRs in the Step Up Program were assisted by a supervisor or lead for a period of four weeks during which time they were monitored and assisted where necessary. During these four weeks CSRs received daily quality audits which helped them gauge their performance. They must meet certain benchmarks in order to graduate from the program. The quality audits were conducted on calls on the same day to provide real-time feedback and to discourage the development of bad habits. Along with quality audits, CSRs were provided with feedback for how they were performing and encouraged to improve through various exercises that they work through with the dedicated lead or supervisor.

A quality auditor also participated in actively updating and improving customer service processes as well as being a SME on the production floor should anyone need assistance. Customer Service processes/work flows were regularly discussed in leadership team meetings and efforts were made to automate processes to reduce call handle times, and ‘Ohana’s dedicated trainer and manager

worked with both the corporate training teams and operations departments to have job aids and training materials updated and to ensure that CareConnects functioned properly.

Customer Service Performance Measures

Customer Service focused on various metrics, including Average Speed of Answer (ASA), Service Level (SL), Average Handle Time (AHT), Customer Satisfaction Survey (CSAT), First Call Resolution (FCR), and quality, to measure success. These performance measures were tracked month over month to ensure that regulatory call center metrics were met. When metrics were not met, root cause analysis was conducted and corrective action was taken. The Customer Service performance measures were trended over the year and were included in the Quality Improvement Evaluation Report. Copies of the report were distributed to the physicians on the Utilization Medical Advisory Board that consisted of external physicians.

A dedicated quality auditor was added to the staff and daily scheduled quality audits were performed for all CSRs on a consistent basis. The number of audits conducted for each CSR increased two fold and audits were conducted daily for calls serviced the day before to provide "real-time" performance scores, to identify areas of concern, and to spotlight areas that were exceptional. If goals were not met, coaching took place between the supervisor and CSRs utilizing notes provided by Quality Auditor.

An additional layer of monitoring was conducted by the State who audited 10 Medicaid calls monthly using a scorecard of their own design. The scorecards were forwarded to Customer Service and the plan responded to any areas of concern and verified that specific actions had been taken regarding member issues.

UnitedHealthcare Community Plan

UHC CP's CAHPS Child Survey Recommendations

QUEST and QExA

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

Improvement Activities Implemented:

Through the Quality Committee structure and workgroups, UHC CP reviewed and analyzed CAHPS results annually and developed plans and initiatives to ensure it continued to provide the highest level of service and experience for members and providers. UHC CP key drivers of satisfaction and the barriers were analyzed. Based on this finding, root cause analysis had been conducted, interventions developed, and opportunities prioritized.

Rating of Health Plan, Rating of All Health Care

- (Ongoing) An EPSDT coordinator contacts members to remind members to make appointments for EPSDT visits and helps resolve problems in making appointments such as unavailable PCP when necessary.
- (Completed and ongoing) Disease Management programs implemented to educate members in the management of their disease including preventive visits. For the QExA program, the plan has disease management programs for obesity, diabetes, substance abuse, and congestive heart failure.
- (Completed) Articles regarding preventive care are published in the quarterly member newsletter.
- (Completed and ongoing) Free workshops are also offered to members across all of the islands (Kauai, Maui, Oahu, and Hawaii). Topics include:
  - Caring for Diabetes
  - Taking Care of Your Heart
  - Healthy Weight, Healthy Life
  - Preventive Health Care and Screenings
  - All About Your UnitedHealthcare Community Plan
  - Is a Disease Management Program Right for You?
- (Completed and ongoing) Developed the HouseCalls and In-Home Assessment Program (IHAP) which is a service available to qualified members of the health plans' Medicare Advantage Dual Special Needs plans which impacts those dual eligibles also in the plan's QExA program. Through this service, healthcare practitioners make an in-home visit to members to assess their health conditions. Through the in-home visit, the plan is able to evaluate the member's current

healthcare needs and make recommendations on how to maintain their health as well as topics to discuss with their primary care physician during their next visit.

- (Completed and ongoing) The health plan partnered with Home Outreach Program & E-Health (H.O.P.E), a chronic disease management program that helps high-risk patients manage their symptoms. The H.O.P.E program uses daily monitoring and feedback from telehealth nurses to reduce both emergency room visits and hospitalizations.
- (Completed) UH CCP shared "Family-Centered Care Self-Assessment Tool" to providers through its newsletter. This is designed to:
  - Increase outpatient healthcare settings' and families' awareness about the implementation of family-centered care.
- (Completed and ongoing) The plan participates and sponsors several community events that promote health education, health literacy, and preventive healthcare. UH CCP also distributes member newsletters with topics including preventive health, health education, health literacy, etc. Free workshops are also offered to members across all of the islands (Kauai, Maui, Oahu, and Hawaii). Topics include:
  - Caring for Diabetes
  - Taking Care of Your Heart
  - Healthy Weight, Healthy Life
  - Preventive Health Care and Screenings
  - All About Your UnitedHealthcare Community Plan
  - Is a Disease Management Program Right for You?
- (Completed and ongoing) Clinical practice guidelines on standards of medical care approved by the health plan's Physician Advisory Council and posted on the website for providers.
- (Completed and ongoing) UHC CP organized and held the Hawaii Quality Conference where primary care providers were educated on HEDIS and important updates. UHC CP also provided information on the plan's available support services to providers.
- (Completed and ongoing) Providers with patients having high levels of gaps in care including preventive care were and are visited to explain HEDIS objectives and requirements.
- (Completed and ongoing) Provider semiannual trainings were conducted including clinical practice guidelines.
- (Completed) Conducted Motivational Interviewing Training (in partnership with Sanofi) to improve service coordinator skills in motivating members for self-management.
- (Completed and ongoing) Conducted quality performance-based guidelines training to all staff. More intensive training was provided to service coordinators and care managers.
- (Completed) Distributed updated member lists with gaps in care to each service coordinator.
- (Completed and ongoing) Processes were developed where members that are identified as unable to locate are periodically included in outreach efforts by service coordinator assistants. Service coordinator assistants also submit address changes to the State.

Rating of Health Plan, Rating of All Health Care, Getting Needed Care

- (Completed) An article regarding how to report PCP changes was published in the member newsletter.
- (Completed and ongoing) Processes were developed on how to change PCP assignments when service coordinators find evidence of a PCP change in their assigned members.
- (Completed and ongoing) All members are screened through the service coordination process. This includes a comprehensive assessment of the member's condition, development and implementation of a care plan which includes monitoring, follow-up, outreach, and engagement of the PCP as needed. The plan assists members who need help navigating the system to facilitate appropriate delivery of care and services.
- (Completed and ongoing) Welcome packets including member handbooks with policies are distributed to members upon enrollment.
- (Completed and ongoing) Customer service staff is trained to answer member inquiries on health plan benefits.
- (Completed and ongoing) Established an online patient portal or integrating online tools and services into current web-based systems focusing on patient-centered care. Online health information and services that can be made available to members include health plan benefits and coverage forms, online medical records, electronic communication with providers, and educational health information and resources on various medical conditions.
- (Completed and ongoing) Provider semiannual trainings were conducted including health plan policies and processes.
- (Completed and ongoing) UH CCP organized and held the Hawaii Quality Conference where primary care providers were educated on the support services that the plan provides.
- (Completed and ongoing) Health plan processes and policies are published in provider newsletters and on the plan's website.
- (Completed and ongoing) Customer service services were brought in-house to provide improved member and provider services. Several provider advocates were also hired to address provider issues.
- (Completed and ongoing) Processes were developed where members that are identified as unable to locate are periodically included in outreach efforts by service coordinator assistants. Service coordinator assistants also submit address changes to the State.

Rating of Health Plan, Getting Needed Care

- (Completed and ongoing) Welcome packets including member handbooks with policies are distributed to members upon enrollment. The member handbook includes a description of the referral process and prior authorization process. As identified, members are also educated and/or reminded of the referral and prior authorization process.
- (Completed and ongoing) Member benefits are published on the health plan website.
- (Completed and ongoing) Customer service staff is trained to answer member inquiries on health plan benefits.
- (Completed and ongoing) The plan's online secure portal allows PCPs to request prior authorization for referrals to out-of-network specialists/providers. These requests are reviewed

and responded to within the time frame allowed by the MQD. Providers are encouraged to call in "URGENT" requests to ensure timely review and response.

- (Completed and ongoing) The Referral and Prior Authorization process is communicated to providers via the biannual provider education and training sessions and as identified through feedback from grievance and appeals reports, Customer Service, Provider Services, Medicare Sales team, and external partners. During the education & education sessions, providers are provided with a Notification/Prior Authorization Quick Reference Guide to help them quickly identify services that require either a notification and/or a prior authorization. The referral and prior authorization process is also communicated through the provider newsletters, Provider Administrative Guide, and other forms of communication.
- (Completed and ongoing) Quarterly timely access surveys are conducted to determine provider compliance with appointment availability standards. Providers who are identified as being noncompliant with the standards are provided with direct education and feedback. Appointment standards are communicated regularly to providers via the Provider Newsletter, Practice Matters and the Provider Administrative Guide.
- (Completed and ongoing) Quarterly PCP and specialty provider availability data are reported, reviewed, and analyzed to determine where gaps in the provider network may limit access to care. Interventions are developed and approved through the Plan's Service Quality Improvement Committee (SQIC).
- (Completed and ongoing) Customer service services were brought in-house to provide improved member and provider services. Several provider advocates were also hired to address provider issues.
- (Completed and ongoing) Processes were developed where members that are identified as unable to locate are periodically included in outreach efforts by service coordinator assistants. Service coordinator assistants also submit address changes to the State.

Rating of All Health Care

- (Completed) An article regarding how to report PCP changes was published in the member newsletter.
- (Completed and ongoing) Processes were developed on how to change PCP assignments when service coordinators find evidence of a PCP change in their assigned members.
- (Completed and ongoing) Service coordinators assist in coordination of medical services to members. Community case managers also assist in coordination of medical services for members in foster homes.
- (Completed and ongoing) Provider semiannual trainings were conducted including plan policies and processes.
- (Completed and ongoing) UH CCP organized and held the Hawaii Quality Conference where primary care providers were educated on the support services that the plan provides.
- (Completed and ongoing) The plan's processes and policies are published in provider newsletters and on the plan's website.
- (Completed and ongoing) Developed a process for major inpatient providers to share admission and discharge data to the plan.

- (Completed and ongoing) Developed a process where service coordinators assist in ensuring that discharged members get post-hospital assessments with their PCP.
- (Completed and ongoing) Service coordinators, community case managers, and behavioral care advocates assist in coordination of medical/behavioral services to member. This includes communicating, with the member's permission, the care that the member receives from other providers. Behavioral care advocates also communicate behavioral healthcare needs of members to the member's assigned service coordinator.
- (Completed and ongoing) A Patient-Centered Medical Home model, which is the basis of the UH CCP Accountable Care Community (ACC) Program was implemented with specific federally qualified medical centers (FQHCs) in which a data analyst and a care advocate work specifically with the FQHC to provide data on care opportunities for members and work to assist with coordination of care on the identified care opportunities. The model is designed to include care coordination, quality, and access improvements across the spectrum of care and services.
- (Completed and ongoing) Customer service services were brought in-house to provide improved member and provider services. Several provider advocates were also hired to address provider issues.
- (Completed and ongoing) Processes were developed where members that are identified as unable to locate are periodically included in outreach efforts by service coordinator assistants. Service coordinator assistants also submit address changes to the State.

Access

- Transport-related grievances continue to be the most prevalent grievance filed. The plan continued to work with LogistiCare to monitor providers and reduce assignment ratios for providers with frequent complaints. The plan also reviewed provider geographic assignments to ensure they are appropriate. In the last half of 2013, the interventions were able to reduce transport providers with three or more issues from 25 to 15 providers. With overall transport utilization increasing with membership increases, an overall reduction throughout the year was not noted.

Attitude/Service

- For grievance subcategories related to providers, a member of the Hawaii Network Management Team reaches out to the provider who is the subject of the grievance to provide feedback and training as needed. For grievance subcategories related to transport providers, a LogistiCare representative reaches out to the provider who is the subject of the grievance to provide feedback and training as needed. LogistiCare monitors providers and reduces assignment ratios for providers with frequent complaints. LogistiCare also considers termination from the transport network. For grievance subcategories related to health plan staff or information, an appropriate health plan manager reaches out to the staff person or department who is the subject of the grievance to provide feedback and training as needed. Health plan management may consider a formal corrective action plan for staff with frequent complaints.

Quality of Care

- For grievances related to quality of care, the grievance team sends the case to the Quality Management Department. They work with providers in the network. They ensure members have appropriate care and timely access to care. They also ensure that quality healthcare services are

provided. The Quality Management Department works with the provider/facility to ensure corrective action is in place where necessary. The plan will continue all interventions and break down the data further to identify additional subcategories for targeted interventions.

Billing/Financial

- For billing/financial grievances related to providers, a member of the Hawaii Network Management Team reaches out to the provider who is the subject of the grievance to provide feedback and training as needed. For grievance subcategories related to members, a plan representative reaches out to the member to educate them on when a share of cost may be appropriate and how to appropriately utilize the plan's utilization management processes and/or participating provider network to avoid out-of-pocket cost.

Quality of Practitioner Office Site

- For grievance subcategories related to providers, a member of the Hawaii Network Management Team reaches out to the provider who is the subject of the grievance to provide feedback and training as needed. Providers are trended and an office site visit is initiated as needed. For grievance subcategories related to transport providers, a LogistiCare representative reaches out to the provider who is the subject of the grievance to provide feedback and training as needed. LogistiCare monitors providers and reduces assignment ratios for providers with frequent complaints. For cases where the accusation caused or may cause a safety issue for the member, a LogistiCare field monitor is sent to inspect the transport provider's vehicles and equipment. LogistiCare may consider termination from the transport network as appropriate.

Appendix A. Methodologies for Conducting EQR Activities

During 2015, HSAG, as the EQRO for the MQD, conducted the following EQR activities for the QUEST Integration health plans and CCS program in accordance with applicable CMS protocols:

- A review of compliance with federal and State requirements for select standard areas (for CCS), and a follow-up reevaluation of compliance following implementation of 2014 CAPs (for the QI plans and CCS)
- Validation of performance measures (i.e., NCQA HEDIS Compliance Audits)
- Validation of PIPs
- A survey of child Medicaid enrollees using the CAHPS Survey
- Provider survey

In addition, HSAG, on behalf of the MQD, conducted the child Medicaid CAHPS survey on a statewide sample of CHIP enrollees who met eligibility and enrollment criteria.

For each EQR activity conducted in 2015, this appendix presents the following information, as required by 42 CFR 438.364:

- Objectives
- Technical methods of data collection and analysis
- Descriptions of data obtained

Compliance Monitoring Review

Objectives

The BBA, as set forth in 42 CFR 438.358, requires that a state or its designee conduct a review to determine each MCO's and PIHP's compliance with federal managed care regulations and state standards. Oversight activities must focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries by the MCO/PIHP. To complete this requirement, HSAG—through its EQRO contract with the MQD—conducted a compliance evaluation of the CCS program health plan. HSAG conducted a desk audit and an on-site review of the health plan to assess the degree to which CCS met federal managed care and State requirements in select standard areas. The primary objective of HSAG's 2015 review was to provide meaningful information to the MQD and the CCS health plan regarding contract compliance with those standards. This review also brought the CCS program into alignment with the QI plans' cycle of compliance monitoring within the three-year period.

The following five standards were assessed for compliance:

- Standard I Member Rights and Protections and Member Information
- Standard II Member Grievance System
- Standard III Access and Availability
- Standard IV Coverage and Authorization
- Standard V Coordination and Continuity of Care

The findings from the desk audit and the on-site review were intended to provide the MQD and CCS with a performance assessment and, when indicated, recommendations to be used to:

- Evaluate the quality and timeliness of, and access to, care furnished by CCS.
- Monitor interventions that were implemented for improvement.
- Evaluate CCS' current structure, operations, and performance on key processes.
- Initiate targeted activities to ensure compliance or enhance current performance, as needed.
- Plan and provide technical assistance in areas noted to have substandard performance.

In addition to the CCS on-site review, HSAG conducted a follow-up review of compliance with federal and State requirements for standard areas for which the QI health plans and CCS had implemented required corrective actions based on findings of deficiency from the 2014 compliance reviews. Once each of the health plans' final compliance review report was produced, the health plan prepared and submitted a CAP for the MQD's and HSAG's review and approval. Once the CAP was approved, the health plan implemented the planned corrective actions and submitted documented evidence that the activities were completed and that the plan was now in compliance. The MQD and HSAG performed a desk review of the documentation and issued a final report of findings once the plan was determined to meet the requirement(s) and was in full compliance.

Technical Methods of Data Collection and Analysis

Prior to beginning the on-site compliance monitoring and follow-up reviews, HSAG, in collaboration with the MQD, developed a customized data collection tool to use in the review of each health plan. The content of the tool was based on applicable federal and State laws and regulations and the Hawaii health plans' and CCS' current contracts.

HSAG conducted the compliance monitoring reviews in accordance with the CMS protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-1]

Description of Data Obtained

To assess the health plans' compliance with federal and State requirements, HSAG obtained information from a wide range of written documents including committee meeting agendas, minutes, and handouts; policies and procedures; reports; member and provider handbooks; monitoring reports; and provider contract templates. For the record reviews conducted at CCS, HSAG generated audit samples based on data files that the health plan provided (i.e., listings of denials, appeals, and grievances processed within the review time period). HSAG also obtained information for the compliance monitoring review through observation during the on-site review and through interaction, discussion, and interviews with key health plan staff members.

At the conclusion of each compliance review, HSAG provided the health plan and the MQD with a report of findings. The plan-specific results are summarized in Section 3 of this report.

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: 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.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

Objectives

As set forth in 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

The following table presents the State-selected HEDIS and performance measures and required methodology for the 2015 validation activities.

Table A-1—Validated HEDIS Measures and Abbreviations

	Measure Name	Non-ABD	ABD	CCS	Methodology
1	*Adherence to Antipsychotics for Individuals With Schizophrenia (SAA)*	√	√	√	Admin
2	*Adolescent Well-Care Visits (AWC)*	√	√		Hybrid
3	*Adult BMI Assessment (ABA)*	√	√		Hybrid
4	*Adults' Access to Preventive/Ambulatory Health Services (AAP)*	√	√		Admin
5	*Ambulatory Care (AMB)*	√	√		Admin
6	*Annual Monitoring for Patients on Persistent Medications (MPM)*	√	√		Admin
7	*Antidepressant Medication Management (AMM)*	√	√		Admin
8	*Behavioral Health Assessment (BHA)**			√	Admin
9	*Breast Cancer Screening (BCS)*	√	√		Admin
10	*Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)*			√	Admin
11	*Care for Older Adults (COA)***		√		Hybrid
12	*Cervical Cancer Screening (CCS)*	√	√		Hybrid†
13	*Childhood Immunization Status (CIS)*	√	√		Hybrid†
14	*Children and Adolescents' Access to Primary Care Practitioners (CAP)*	√	√		Admin

Table A-1—Validated HEDIS Measures and Abbreviations					
	Measure Name	Non-ABD	ABD	CCS	Methodology
15	*Chlamydia Screening in Women (CHL)*	√	√		Admin
16	*Colorectal Cancer Screening (COL)***	√	√		Hybrid†
17	*Comprehensive Diabetes Care (CDC)*	√	√		Hybrid†
18	*Controlling High Blood Pressure (CBP)*	√	√		Hybrid
19	*Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)*			√	Admin
20	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*			√	Admin
21	*Enrollment by Product Line (ENP)*	√	√	√	Admin
22	*Follow-Up After Hospitalization for Mental Illness (FUH)*	√	√	√	Admin
23	*Follow-Up of Care for Children Prescribed ADHD Medication (ADD)*	√	√		Admin
24	*Follow-Up with Assigned PCP Following Hospitalization for Mental Illness (FUP)**			√	Admin
25	*Frequency of Ongoing Prenatal Care (FPC)*	√	√		Hybrid†
26	*Human Papillomavirus Vaccine for Female Adolescents (HPV)*	√	√		Hybrid†
27	*Immunizations for Adolescents (IMA)*	√	√		Hybrid†
28	*Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)*	√	√	√	Admin
29	*Inpatient Utilization—General Hospital/Acute Care (IPUA)*	√	√		Admin
30	*Medication Management for People With Asthma (MMA)*	√	√		Admin
31	*Medication Reconciliation Post-Discharge (MRP)***		√		Hybrid
32	*Mental Health Utilization (MPT)*	√	√	√	Admin
33	*Persistence of Beta Blocker Treatment After a Heart Attack (PBH)*	√	√		Admin
34	*Pharmacotherapy Management of COPD Exacerbation (PCE)*	√	√		Admin
35	*Plan All-Cause Readmissions (PCR)***	√	√	√	Admin
36	*Prenatal and Postpartum Care (PPC)*	√	√		Hybrid
37	*Use of Appropriate Medications for People With Asthma (ASM)*	√	√		Admin
38	*Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)*		√		Admin

Table A-1—Validated HEDIS Measures and Abbreviations					
Measure Name		Non-ABD	ABD	CCS	Methodology
39	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	√	√		Hybrid
40	*Well-Child Visits in the First 15 Months of Life (W15)*	√	√		Hybrid†
41	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*	√	√		Hybrid†

**These measures are state-specified, non-HEDIS measures.*
***These measures were not Medicaid measures. The MQD required the PCR measure to be reported applying the Medicare weighting tables for the ABD and CCS populations and the Commercial weighting tables for the non-ABD population.*
†Kaiser received approval from the MQD to report nine measures via the Administrative methodology. These measures were CIS, CCS, COL, CDC, HPV, FPC, IMA, W15, and W34. For CDC, Kaiser was required to report the Eye Exam indictor using the Hybrid methodology.

Technical Methods of Data Collection and Analysis

HSAG validated the performance measures calculated by health plans for various population types (non-ABD, ABD, and CCS) using selected methodologies presented in the *2015 NCQA HEDIS Compliance Audit Standards, Policies and Procedures, HEDIS Volume 5*. The measurement period reviewed for the health plans was concurrent (CY 2014) and followed the NCQA HEDIS timeline for reporting rates.

The same process was followed for each performance measure validation conducted by HSAG and included: (1) pre-review activities such as development of measure-specific work sheets and a review of completed plan responses to the HEDIS Record of Administration, Data Management, and Processes (Roadmap); and (2) on-site activities such as interviews with staff members, primary source verification, programming logic review and inspection of dated job logs, and computer database and file structure review.

HSAG validated the health plans' IS capabilities for accurate reporting. The review team focused specifically on aspects of the health plans' systems that could affect the selected measures. Items reviewed included coding and data capture, transfer, and entry processes for medical data; data capture, transfer, and entry processes for membership data; data capture, transfer, and entry processes for provider data; medical record data abstraction processes; the use of supplemental data sources; and data integration and measure calculation. If an area of noncompliance was noted with any IS standard, the audit team determined if the issue resulted in significant, minimal, or no impact to the final reported rate.

Each HEDIS measure verified by the HSAG review team received an audit result consistent with one of the four NCQA categories listed in the following table.

Table A-2—NCQA Audit Results	
NCQA Category for Measure Audit Result	**Meaning**
R = Report	*A rate or numeric result.* The health plan followed the specifications and produced a reportable rate or result for the measure.
NA = Not Applicable	*Small Denominator*. The health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB = No Benefit	*Benefit Not Offered.* The health plan did not offer the health benefit required by the measure (e.g., mental health).
NR = Not Reportable	*Not Reportable.* 1. The calculated rate was materially biased, ***or*** 2. The health plan chose not to report the measure, ***or*** 3. The health plan was not required to report the measure.

For the purposes of comparison and assessment of improvement over time as depicted in this report, HSAG used the *t*-test to examine whether statistically significant differences between HEDIS 2014 (CY 2013) rates and HEDIS 2015 (CY 2014) rates existed. A difference was considered statistically significant if the *p* value was less than 0.05. Statistical significance testing was only performed on measures where rates are presented as percentages. Measures with statistically significant improvement were denoted in **green**, showing the magnitude of the percentage point differences. Similarly, measures with statistically significant decline were denoted in **red**. For inverse measures where a lower rate indicates better performance (e.g., *Comprehensive Diabetes Care—HbA1c Poor Control*), a statistically significant decline was shown in **red** with positive percentage point differences. Conversely, a statistically significant improvement was shown in **green** with negative percentage point differences. Measures for which there was no statistically significant change were shown with the percentage point increase or decrease in black.

Description of Data Obtained

HSAG used a number of different methods and sources of information to conduct the validation. These included:

- Completed responses to the HEDIS Roadmap published by NCQA as Appendix 2 to the *HEDIS 2015, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures.*
- Source code, computer programming, and query language (if applicable) used by the health plans to calculate the selected measures.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Re-abstraction of a sample of medical records selected by HSAG auditors for the health plans.

Information was also obtained through interaction, discussion, and formal interviews with key staff members, as well as through system demonstrations and data processing observations.

After completing the validation process, HSAG prepared a report of the performance measure review findings and recommendations for the MQD and each health plan. The plan-specific results are summarized in Section 3 of this report; and in Section 4, a comparison of all plans' results is provided.

Validation of Performance Improvement Projects

Objectives

As part of the State's quality strategy, each health plan was required by the MQD to conduct performance improvement projects (PIPs) in accordance with 42 CFR 438.240. Annual validation of PIPs is one of the mandatory EQR activities required under the Balanced Budget Act of 1997 (BBA). HSAG, as the State's EQRO, validated the PIPs through an independent review process. The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. For such projects to achieve meaningful and sustained improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner. To ensure methodological soundness while meeting all state and federal requirements, HSAG follows guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (the PIP protocol).[A-2]

The primary objective of the PIP validation was to determine the health plans' achievement of PIP module criteria, including:

- Integration of quality improvement science.
- Formation of teams.
- Setting aims.
- Establishing measures.

In 2015, HSAG performed the validation activities on 12 PIPs submitted by the Hawaii Medicaid health plans, as described in the following table:

Table A-3—2015 Validated PIPs

Health Plan	PIP Topic
AlohaCare	1. *All-Cause Readmissions* 2. *Diabetes Care*
HMSA	1. *All-Cause Readmissions* 2. *Diabetes Care*
Kaiser	1. *All-Cause Readmissions* 2. *Diabetes Care*
'Ohana	1. *All-Cause Readmissions* 2. *Diabetes Care*

[A-2] 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: February 19, 2015.

Table A-3—2015 Validated PIPs	
UHC CP	1. *All-Cause Readmissions* 2. *Diabetes Care*
CCS	1. *Follow-Up After Hospitalization for Mental Illness* 2. *Initiation of Alcohol and Substance Abuse Treatment*

While the primary purpose of HSAG's PIP validation methodology was to assess the integration of quality improvement science and processes for conducting PIPs, HSAG also identified that the health plans' PIPs contained measures related to the quality, access, and timeliness domains. More specifically, all 12 PIPs provided opportunities for the health plans to improve the quality of care for their members.

Technical Methods of Data Collection and Analysis

HSAG's validation of PIPs includes the following two key components of the quality improvement process:

1. Evaluation of the technical structure to determine whether a PIP's initiation (e.g., 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.
2. 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.

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.

HSAG obtained the data needed to conduct the PIP validations from the health plans' PIP Module submission forms. These forms provided detailed information about each health plan's PIPs related to the criteria completed, and HSAG evaluated for the 2015 validation cycle.

PIP Components and Process

HSAG and some of its contracted states have identified that, while managed care organizations (MCOs) have designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few MCOs have achieved real and sustained improvement. 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 new methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement.

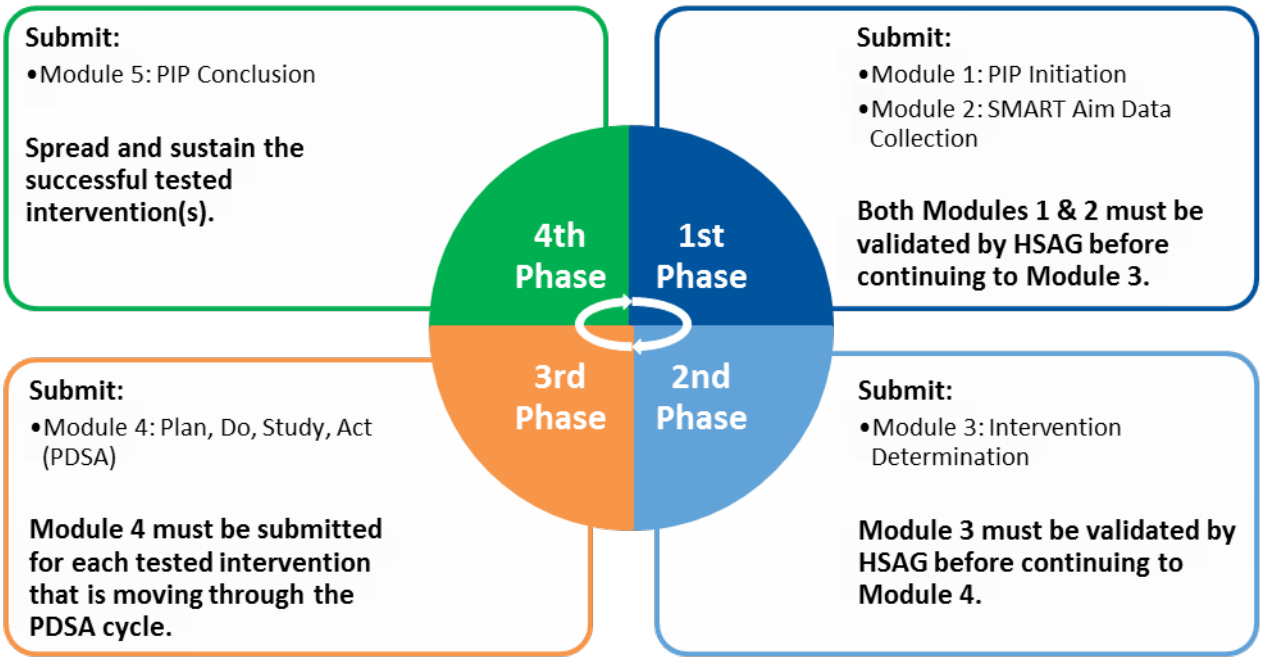
Because PIPs must meet CMS' requirements, HSAG completed a crosswalk of this new framework against the PIP protocol. HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocol activities. CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within healthcare settings, a new approach was needed.

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 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. HSAG anticipates that the duration of PIPs using this new framework will be 12–18 months depending on the project and any challenges that may arise.

For this new PIP framework, HSAG developed five modules, each with a companion guide.

- Module 1—PIP Initiation: Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- Module 2—SMART Aim Data Collection: In Module 2, the SMART Aim measure is outlined, and the data collection methodology is described. The data for the SMART Aim will be displayed using a run chart.
- Module 3—Intervention Determination: In Module 3, the quality improvement activities that can impact the SMART Aim are identified. Through the use of process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, interventions are selected to test in Module 4.
- Module 4—Plan-Do-Study-Act: The interventions selected in Module 3 are tested and evaluated through a series of PDSA cycles.
- Module 5—PIP Conclusions: Module 5 summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

The process flow below illustrates the progression in which the five modules will be submitted and validated throughout the PIP process.



In the first (initiation) phase, HSAG works with each health plan and the State to determine the timeline for the four phases. The health plans must complete modules 1 and 2 during the first phase and Module 3 during the second phase. Modules 1 through 3 will create the basic infrastructure and identify interventions to test. In the third phase of the PIP, the health plan will test the interventions on a small scale using the PDSA cycle. This should be the longest phase as the health plan will test a number of interventions. Module 4 must be submitted for each tested intervention. Completion of Module 5 will occur once all interventions have been tested and the analysis of the PDSA cycles is complete. Module 5 summarizes the results of the tested interventions. At the end of the PIP, the health plan will have identified successful interventions that can be expanded on a larger scale to achieve the desired healthcare outcomes.

Training

HSAG's new PIP approach was initiated in the State of Hawaii to coincide with the implementation of the new QI program. HSAG worked with the MQD to develop a plan for training, monitoring, and oversight. HSAG was involved from the onset of the PIPs to ensure that each PIP was methodologically sound and the health plans had the knowledge and guidance needed to be successful.

In January 2015, HSAG conducted webinars to introduce the new PIP framework to the MQD and health plans. Over the course of several months, HSAG conducted additional, module-specific training webinars. These sessions went into greater detail and provided specific direction for each module. The health plans have also been encouraged to seek ongoing, individualized technical assistance throughout the PIP process as needed.

HSAG provided written feedback to the health plans after each module was completed and submitted for review. Along with this feedback, HSAG offered technical assistance phone conferences to each health plan to provide further clarification on the recommendations for each module. HSAG's new PIP validation process facilitates more frequent technical assistance for the health plans throughout the PIP process.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Surveys

Objectives

The primary objective of the Child Medicaid CAHPS survey was to effectively and efficiently obtain information on the levels of satisfaction of the Hawaii Medicaid child members with their health plan and healthcare experiences. Results were provided at both plan-specific and statewide aggregate levels.

The primary objective of the CHIP CAHPS survey was to obtain satisfaction information from the Hawaii CHIP population to provide to the MQD and to meet the State's obligation for CHIP CAHPS measure reporting to CMS. Results were provided to the MQD in a statewide aggregate report.

Technical Methods of Data Collection and Analysis

Data collection for the Child CAHPS survey was accomplished through administration of the CAHPS 5.0H Child Medicaid Health Plan Survey instrument (without the Children with Chronic Conditions [CCC] measurement set) to child Medicaid and CHIP members of the QI health plans. Child members included as eligible for the survey were 17 years of age or younger as of December 31, 2014. 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 languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese. The CAHPS 5.0H Health Plan Survey process allows for two methods by which members can complete a survey: mail and telephone. During the mail phase, the cover letters provided with the English version of the CAHPS survey questionnaire included additional text in Chinese, Ilocano, Korean, and Vietnamese informing parents/caretakers of sampled members that they could call a toll-free number to request to complete the survey in one of these designated alternate languages. The toll-free line for alternate survey language requests directed callers to select their preferred language for completing the survey (i.e., Chinese, Ilocano, Korean, or Vietnamese) and leave a voice message for an interpreter service that would return their call and subsequently schedule an appointment to complete the survey via computer assisted telephone interviewing (CATI). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled members who had not mailed in a completed survey or requested the option to complete the survey in an alternate language (i.e., Chinese, Ilocano, Korean, or Vietnamese). It is

important to note that the CAHPS 5.0H Child Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. Therefore, prior to the start of the CAHPS Survey process and in following NCQA HEDIS specifications, a request for a survey protocol enhancement was submitted to NCQA to allow the QI health plan members the option to complete the CAHPS survey in the designated alternate languages (i.e., Chinese, Ilocano, Korean, and Vietnamese). Subsequently, NCQA's approval of this survey protocol enhancement was received. The participating QI health plans included AlohaCare QI, HMSA QI, Kaiser QI, 'Ohana QI, and UHC CP QI. The 'Ohana CCS program enrollees were not separately sampled as they were already included in the population sampled for the QI health plan in which they were enrolled.

The Child CAHPS survey included a set of standardized items (48 questions) that assessed parents'/caretakers' perspectives on their child member's care. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed to select the child members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. An analysis of the CAHPS 5.0H Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[A-3] NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result; however, for purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

The survey questions were categorized into 11 measures of satisfaction. These measures included four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, healthcare, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., Getting Needed Care or Getting Care Quickly). The individual item measures are individual questions that consider a specific area of care (i.e., Coordination of Care, and Health Promotion and Education).

It is important to note that with the release of the 2015 CAHPS 5.0H Medicaid Health Plan Surveys, changes were made to the question language and response options for the *Shared Decision Making* composite measure. Due to these changes, for the QI health plans, comparisons to national data could not be performed for the *Shared Decision Making* composite measure. For the statewide CHIP population, comparisons to national data and the prior year's rate could not be performed for the *Shared Decision Making* composite measure.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction rating (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate. In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were

[A-3] National Committee for Quality Assurance. *HEDIS® 2015, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2014.

given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (i.e., 1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite questions' response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always"; or (2) "No" and "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures.

In addition to the global proportions, a three-point mean was calculated for four of the composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*). Scoring was based on a three-point scale. Responses of "Usually/Always" were given a score of 3, responses of "Sometimes" were given a score of 2, and all other responses were given a score of 1. The three-point mean was the average of the mean score for each question included in the composite.

For the individual item measures, the percentage of respondents who chose a positive response was calculated. Response choices for CAHPS individual items fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always"; or (2) "No" and "Yes." A positive or top-box response for the individual items was defined as a response of "Usually/Always" for the *Coordination of Care* individual item and "Yes" for *Health Promotion and Education*. The percentage of top-box responses is referred to as a question summary rate for the individual item measures.

For each CAHPS measure, the resulting three-point mean scores were compared to NCQA's 2015 HEDIS Benchmarks and Thresholds for Accreditation, except for the *Shared Decision Making* composite and *Coordination of Care* and *Health Promotion and Education* individual items.[A-4] NCQA does not publish benchmarks and thresholds for these CAHPS measures; therefore, star ratings could not be derived. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating and five being the highest possible rating, using the following percentile distributions:

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

[A-4] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2015*. Washington, DC: NCQA, February 5, 2015.

Additionally, HSAG performed a trend analysis of the statewide CHIP results.[A-5,A-6] For the statewide CHIP population, 2015 CAHPS scores were compared to their corresponding 2014 CAHPS scores to determine whether there were statistically significant differences, where appropriate. Lastly, the QI health plans' and the QI statewide aggregate's 2015 CAHPS scores were compared to 2014 NCQA National Child Medicaid averages. The statewide CHIP population's 2015 CAHPS scores were also compared to 2014 NCQA National Child Medicaid averages. These comparisons were performed for the four global ratings, four composite measures, and two individual item measures.

Description of Data Obtained

The CAHPS survey asks members to report on and to evaluate their experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The children's surveys were administered from February to May 2015 and were designed to achieve the highest possible response rate. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), or they had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the Child CAHPS surveys, HSAG provided each health plan and the MQD with a plan-specific report of findings; and a statewide aggregate report was provided to the MQD. The MQD also received a statewide aggregate report of the CHIP survey results.

The plan-specific results of the Child CAHPS survey are summarized in Section 3 of this report; and in Section 4, a statewide comparison of all plan results is provided.

Provider Survey

Objective

The objective of the provider survey was to provide feedback to the MQD and the health plans about providers' perceptions of the QI health plans.

[A-5] 2015 represents the first year child members of the QUEST Integration (QI) health plans (i.e., AlohaCare, HMSA, Kaiser, 'Ohana, and UHC CP QI) were surveyed; therefore, a trend analysis could not be performed for these plans.
[A-3] HSAG did not survey the child Medicaid population in 2014.

Technical Methods of Data Collection and Analysis

The method of data collection was through the administration of the 2015 Hawaii Provider Survey to a random sample of 1,500 providers: 400 Kaiser providers and 1,100 non-Kaiser providers (i.e., AlohaCare QI, HMSA QI, 'Ohana CCS, 'Ohana QI, and UnitedHealthcare Community Plan QI). Providers eligible for sampling included those who served the Hawaii Medicaid population and contracted with at least one of the QI health plans. The survey administration consisted of mailing sampled providers a survey questionnaire, cover letter, and business reply envelope. For providers with available email addresses, an electronic reminder was sent via email communication. Providers were given two options by which they could complete the surveys: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey by logging on to the survey website with a designated, provider-specific login. The survey was administered from May to July 2015 and included 15 questions that surveyed providers on a broad range of topics.

Results were determined within six domains of satisfaction: General Positions, Providing Quality Care, Formulary, Service Coordinators, Specialists, and Behavioral Health. Response options to each question within these domains were classified into one of three response categories: satisfied, neutral, and dissatisfied. For each question, the percentage of respondents in each of the response categories was calculated. Health plan survey responses were not limited to those providers who indicated they were currently accepting new patients for that health plan in Question 1 of the survey. For example, if a provider indicated that he/she was not at this time accepting new patients for AlohaCare in Question 1, his/her responses would be included in the results pertaining to AlohaCare if a response had been provided. Therefore, providers may have rated a health plan on a survey question even if they were not currently accepting new patients for that plan. Furthermore, if a provider was associated with more than one health plan, he/she may have answered a question for multiple health plans.

Standard tests of statistical significance were conducted, where applicable, to determine if statistically significant differences in performance across health plans existed. As is standard in most survey implementations, a "top-box" rate was defined by a positive or satisfied response.

HSAG performed a trend analysis of participating QI health plans' results. Each health plan's 2015 Provider Survey results were compared to their corresponding 2013 Provider Survey results, where applicable, to determine whether there were statistically significant differences.[A-7,A-8]

Description of Data Obtained

The survey covered topics for primary care and specialty providers including the impact of plans' prior authorization procedures and formulary on the providers' ability to provide quality care. Additional survey questions elicited information about reimbursement satisfaction, adequacy of access to non-formulary drugs, service coordinators, adequacy of access to specialty providers, and licensed behavioral health providers. The response rate was the total number of completed surveys

[A-7] The provider survey was not administered in 2014.

[A-8] The MQD elected to modify the provider survey instrument administered in 2013; therefore, the 2015 Hawaii Provider Survey instrument contained new survey questions for which trending could not be performed.

divided by all eligible providers within the sample. Eligible providers included the entire random sample minus ineligible providers, which included any provider that could not be surveyed due to incorrect or incomplete contact information or that had indicated the provider had no current contract with any of the health plans.

Following the administration of the provider survey, HSAG provided the MQD with an aggregate report of plan-specific findings. The plan-specific results are summarized in Section 3 of this report; and in Section 4, a statewide comparison of all plan results is provided.