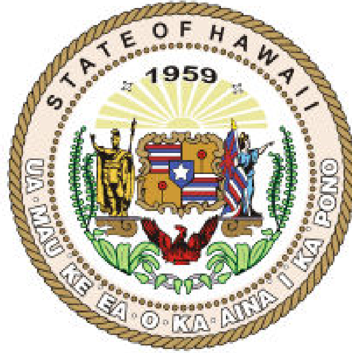
State of Hawaii

Department of Human Services

Med-QUEST Division



2017 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

April 2018

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Overview

The 2017 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) Health Plans and the Community Care Services (CCS) program is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR §438.364.[1-1] Health Services Advisory Group, Inc. (HSAG), is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), the single State agency responsible for the overall administration of Hawaii's Medicaid managed care program.

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

Purpose of the Report

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

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

This report provides:

- An overview of the QI and CCS programs.

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

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

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

Scope of EQR Activities

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

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

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

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

Overall Summary of Health Plan Performance

Compliance Monitoring Review

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

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

Findings, Conclusions, and Recommendations

Table 1-1 summarizes the results from the 2017 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

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

Table 1-1—Standards and Compliance Scores

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

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

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

Individual health plan performance revealed the following:

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

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

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

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

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

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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

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

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

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

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

Findings, Conclusions, and Recommendations

NCQA HEDIS Compliance Audit

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

Performance Measure Results

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

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

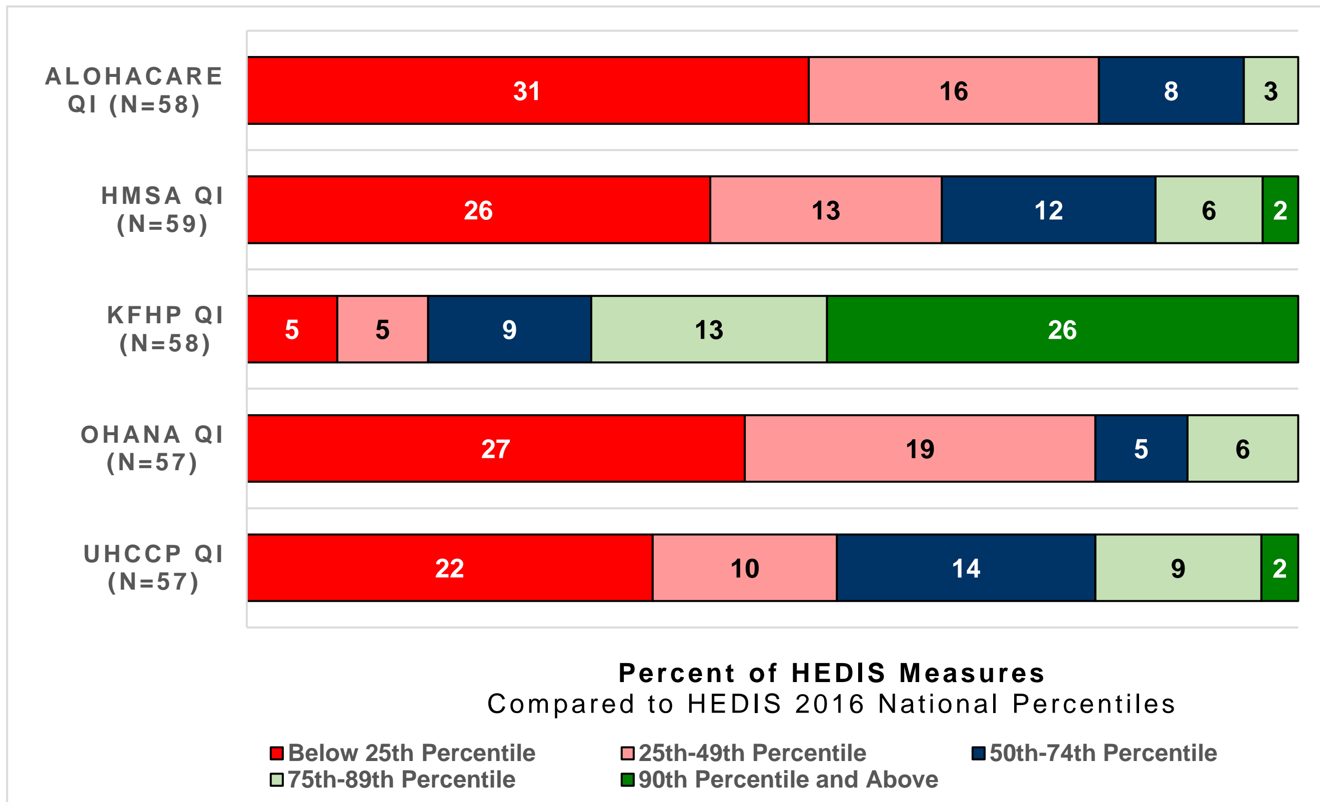
For QI health plans, HSAG validated 33 HEDIS 2017 performance measures, resulting in a total of 96 separate indicator rates reported across all audited measures, of which 60 indicators were compared to national Medicaid HEDIS 2016 percentiles.[1-9] None of the plans reported all 60 indicators. AlohaCare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

[1-8] For example, because the value associated with the national 10th percentile reflects better performance, HSAG reversed the percentile to the measure's 90th percentile. Similarly, the value associated with the 25th percentile was reversed to the 75th percentile.

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

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

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



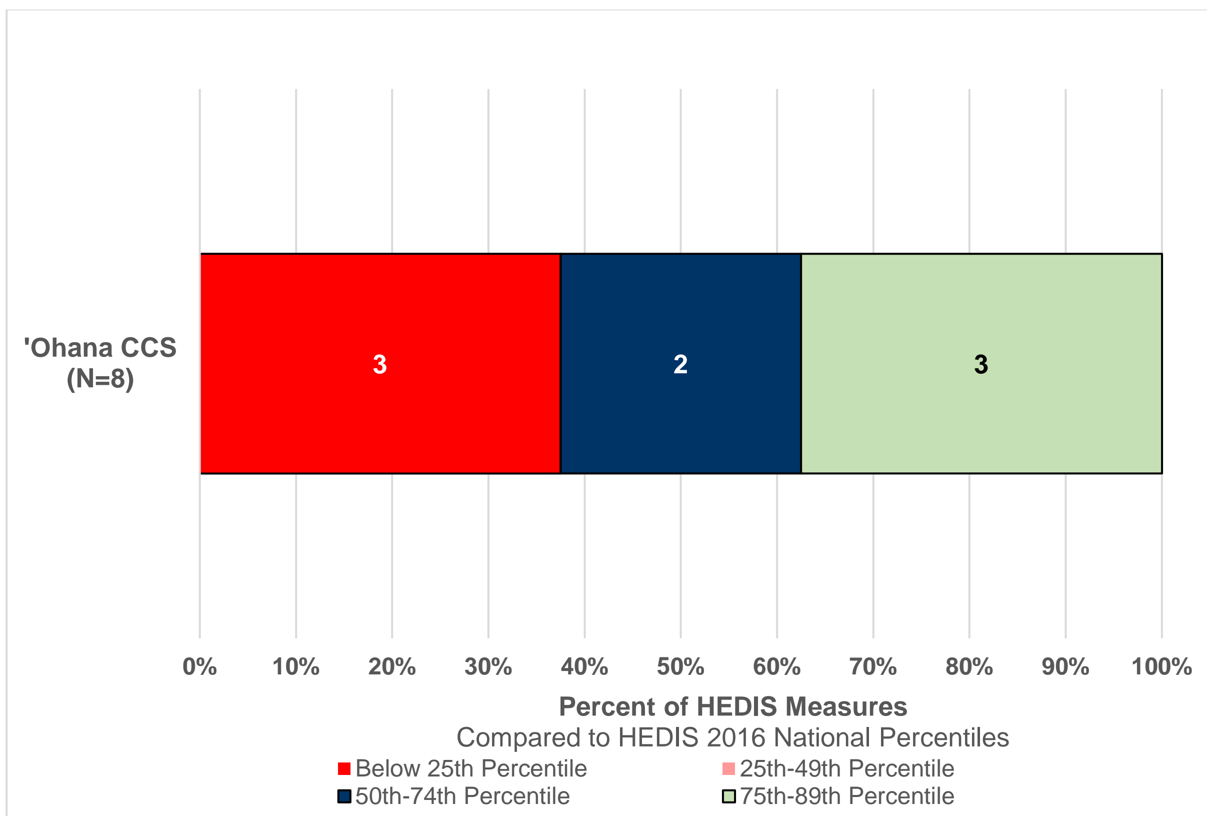
As presented in Figure 1-1, the plans were diverse in their performance. KFHP QI, the best-performing plan for HEDIS 2017, reported 26 of 58 indicators (45 percent) at or above the HEDIS 2016 national Medicaid 90th percentile, along with 13 indicators (22 percent) at or above the national 75th percentile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

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

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

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

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



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

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

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Performance Improvement Projects

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

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

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

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

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

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

Findings, Conclusions, and Recommendations

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

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

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

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

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

CAHPS—Child Survey

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

Survey instrument (without the CCC measurement set) to child Medicaid and CHIP members of the QI health plans who met age and enrollment criteria. All members of sampled child Medicaid and CHIP members completed the surveys from February to May 2017 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.[1-11] Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan and/or state-level CAHPS data.

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

Findings, Conclusions, and Recommendations

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

Table 1-2—2017 QUEST Integration Child CAHPS Results

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

[1-11] Please note that administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.0H Child Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.
[1-12] The QI Program aggregate results were derived from the combined results of the five participating QI health plans.
[1-13] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017.* Washington, DC: NCQA, May 4, 2017.

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

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

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

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

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

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

As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparative purposes. Table 1-3 presents the question summary rates and global proportions for the Hawaii CHIP population.

Table 1-3—Comparison of 2017 CHIP CAHPS Results

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

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

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

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

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

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

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

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

2. Introduction

Purpose of the Report

As required by CFR §438.364,[2-1] the MQD contracts with HSAG, an EQRO, to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access and quality of care, including:

- A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity.
- For each EQR-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
  - Conclusions drawn from the data
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431,433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Mar 1, 2018.

Quality Strategy Annual Assessment

In accordance with 42 CFR §438.340, each state contracting with an MCO, PIHP, or PAHP, as defined in §438.2 or with a PCCM entity as described in §438.310(c) must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO, PIHP, PAHP, or PCCM entity.

Compliance Reviews

The Balanced Budget Act of 1997 (BBA), as set forth in 42 CFR §438.358, requires that the state or its designee conduct a review within the previous three-year period to determine the MCO's, PIHP's, PAHP's, or PCCM entity's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.

Performance Measures

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of the MCOs', PIHPs', PAHPs', and PCCM entities' quality assessment and performance improvement (QAPI) programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(2). The EQR technical report must include information on the validation of MCO, PIHP, PAHP, or PCCM entity performance measures (as required by the state) or MCO, PIHP, PAHP, and PCCM entity performance measures calculated by the state during the preceding 12 months. To comply with §438.358, MQD contracted with HSAG to conduct an independent validation, through NCQA HEDIS Compliance Audits and performance measure validation for non-HEDIS measures, of the MQD-selected performance measures calculated and submitted by QI plans.

Performance Improvement Projects

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.358(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve quality improvement
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

The EQR technical report must include information on the validation of performance improvement projects required by the state and underway during the preceding 12 months.

Consumer Surveys

Administration of consumer surveys of quality of care is one of the optional external quality review activities described at 42 CFR §438.358(c)(2).

Technical Assistance

At the state's direction, the EQRO may provide technical guidance to groups of MCPs, PIHPs, PAHPs, or PCCM entities as described at 42 CFR §438.358(d).

Summary of Report Content

Encompassing a review period from January 1, 2017, through December 31, 2017, this report provides:

- A description of Hawaii's Medicaid service delivery system.
- A description of MQD's quality strategy.
- A description of the scope of EQR activities including the methodology used for data collection and analysis, a description of the data for each activity, and an aggregate assessment of health plan performance related to each activity, as applicable.
- A description of HSAG's assessment related to the three federally mandated activities, one optional activities, and the technical assistance provided to MQD as set forth in 42 CFR §438.358:
  - Mandatory activities:
    - Compliance monitoring reviews
    - Validation of performance measures
    - Validation of PIPs
  - Optional activities:
    - Administration of consumer surveys
    - Technical assistance
- A description of the methodologies used to conduct EQR activities included as an appendix.

Overview of the Hawaii Medicaid Service Delivery System

The Hawaii Medicaid Program

Medicaid covers more than 360,000[2-2] 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, "empower Hawai'i's residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality programs with aloha."[2-3] The MQD has adapted the Institute of Medicine's (IOM's) framework of quality and strives to provide care for its members that is:

- *Safe*—prevents medical errors and minimizes risk of patient harm.
- *Effective*—evidence-based services consistently delivered to the population known to benefit from them.
- *Efficient*—cost-effective utilization that avoids waste, including waste of equipment, supplies, ideas, and energy.
- *Patient-centered*—respectful of and responsive to an individual's preferences, needs, and values.
- *Timely*—medically appropriate access to care and healthcare decisions with minimal delay.
- *Equitable*—without disparities based on gender, race, ethnicity, geography, and socioeconomic status.

Over the past several years, 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 CHIP members, 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 QI program beginning January 1, 2015. The QI program melded 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

[2-2] All Medicaid enrollment statistics cited in this section are as of December 2017, as cited in *Hawaii Medicaid Enrollment for the Year 2017,* available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/enrollment-reports/2017-Hawaii-Medicaid-Managed-Care-Enrollment-Jan-Dec-2017.pdf. Accessed on: Mar 1, 2018.

[2-3] Hawaii Department of Human Services, Med-QUEST Division. Mission Statement. Available at: https://medquest.hawaii.gov/en/about/mission-statement.html. Accessed on: April 26, 2018.

enrolled members, including primary, preventive, acute, and long-term services and supports. The goals of the QI program are to:

- Improve the healthcare status of the member population.
- Minimize administrative burdens, streamline access to care for members with changing health status, and improve health outcomes by integrating programs and benefits.
- Align the program with the Affordable Care Act (ACA) of 2010.
- 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 QI
- HMSA QI
- KFHP QI
- 'Ohana QI
- UHC CP QI

All QI health plans provide Medicaid services statewide (i.e., on all islands) except for KFHP QI, 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 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 QI

AlohaCare QI 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 QI serves over 70,500 Medicaid members in its QI health plan and provides a dual special needs plan for dually eligible Medicare and Medicaid beneficiaries. AlohaCare QI contracts with a large network of providers statewide, emphasizing prevention and primary care. AlohaCare QI 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 the islands.

Hawaii HMSA QI

HMSA QI, 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 QI is the largest provider of healthcare coverage in the State and the largest QI plan, serving over 167,500 enrolled Medicaid members. The vast majority of Hawaii's doctors, hospitals, and other providers participate in HMSA QI's network. HMSA QI has been a Medicaid contracted health plan since 1994.

KFHP QI

Established by Henry J. Kaiser in Honolulu in 1958, KFHP QI's service delivery in Hawaii is based on a relationship between the Kaiser Foundation Health Plan and the Hawaii Permanente Medical Group of physicians and specialists. With its largely "staff-model" approach, KFHP QI operates clinics on several islands and a medical center on Oahu, with additional hospitals and specialists participating through contract arrangements. KFHP QI administers Medicaid, Medicare Advantage, Health Insurance Marketplace, and commercial health plans and provides care to over 30,000 enrolled Medicaid members on the islands of Maui and Oahu.

‘Ohana QI

‘Ohana QI 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 QI began operating in Hawaii on February 1, 2009, initially as a QUEST Expanded Access (QExA) plan, then in July 2012 also as a QUEST plan. ‘Ohana QI currently provides services to nearly 42,500 Medicaid members.

UHC CP QI

UHC CP QI is offered by UnitedHealthcare Insurance Company, one of the largest Medicaid health plan providers in the nation. Providing care to more than 48,500 Medicaid members in Hawaii, UHC CP also administers Medicare dual-eligible 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.

‘Ohana CCS

‘Ohana Health Plan became operational as the State’s CCS behavioral health program in March 2013, serving seriously mentally ill Medicaid recipients enrolled in the QI plans. The ‘Ohana 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[2-4]

In keeping with the requirements specified by CFR §438.202, the QUEST Integration Quality Strategy was filed with CMS in 2014 and approved in July 2016. The *purpose* of the strategy is:

- Monitoring that services provided to members conform to professionally recognized standards of practice and code of ethics.
- Identifying and pursuing opportunities for improvements in health outcomes, accessibility, efficiency, member and provider satisfaction with care and service, safety, and equitability.
- Providing a framework for the MQD to guide and prioritize activities related to quality.
- Assuring that an information system is in place to support the efforts of the quality strategy.

As noted above, the MQD’s Quality Strategy strives to ensure members receive high-quality care that is safe, efficient, patient-*centered*, timely, value/quality-based, data-driven, and equitable by providing oversight of health plans and other contracted entities to promote accountability and transparency for improving health outcomes. The MQD identified and monitors six key goals for the Hawaii Medicaid program:

1. Improve preventive care for women and children.
2. Improve healthcare for individuals who have chronic illnesses.
3. Improve member satisfaction with health plan services.
4. Improve cost efficiency of health plan services.
5. Expand access to HCBS and assure that individuals have a choice of institutional and HCBS.
6. Improve access to community living and the opportunity to receive services in the most integrated setting appropriate for individuals receiving HCBS.

While the MQD Quality Strategy Leadership Team (QSLT) and Quality Strategy Committees (QSCs) are responsible for managing the quality oversight process (including the monitoring of quality

[2-4] QUEST Integration Quality Strategy. State of Hawaii, Department of Human Services, Med-QUEST Division. Available at: http://www.med-quest.us/PDFs/Quality%20Strategy/HI%20MQD%20Quality%20Strategy%20Approved.pdf. Accessed on Mar 1, 2018.

initiatives, tracking progress over time, and developing recommendations for improvement), the Health Care Services Branch (HCSB) at the MQD actively collects and reviews all monitoring and quality reports, organizing the results to support the MQD's oversight activities through plan-to-plan comparisons and trending analyses.

The MQD uses monthly, quarterly, and annual reporting from its EQRO and MCOs to monitor its success in meeting the key goals/measures of the Quality Strategy. The MQD continues to make progress on implementing its quality initiatives through ongoing monitoring, assessments of progress toward meeting strategic goals, and evaluating the relevance of its Quality Strategy. The MQD conducted the following activities to support progress in implementing the Quality Strategy.

- The MQD regularly monitors the effectiveness of health plans in achieving the goals above through EQR activities and reports. The MQD has contracted with HSAG to perform both mandatory and optional activities 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 and CHIP population CAHPS survey, and technical assistance to the MQD and health plans.
- The MQD annually defines a set of performance measures to monitor progress in improving preventive care for women and children, healthcare for individuals who have chronic conditions, and the cost-efficiency of health plans' services. In collaboration with the healthcare community, measures are reviewed and selected each year to support the measurement, tracking, and improvement of performance and outcomes. The MQD and HSAG also work to define additional measures to incorporate that address access to HCBS. A subset of measures is incorporated into the MQD's Pay-for-Performance (P4P) incentive program.
- The MQD and HSAG continued to work with the health plans in implementing a rapid-cycle PIP framework to test and refine interventions through a series of PDSA cycles designed to facilitate more efficient and long-term sustained improvement. In 2017, the health plans tested and evaluated selected interventions and summarized key findings regarding the outcomes of their interventions.

The MQD will continue to work with key stakeholders to evaluate the Quality Strategy in light of changes initiated with the final managed care rules.

Introduction

This section of the report describes the results of HSAG's 2017 EQR activities and conclusions as to the strengths and weaknesses of each health plan about the quality of, timeliness of, and access to care furnished by the Hawaii Medicaid health plans serving the QUEST Integration members. Additionally, recommendations are offered to each health plan to facilitate continued quality improvement in the Medicaid program.

Methodology

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes how data were aggregated and analyzed and how conclusions were drawn as to the quality of, timeliness of, and access to care and services furnished by the states' health plans. The data come from activities conducted in accordance with 42 CFR §438.358. From all the data collected, HSAG summarized each health plan's performance, with attention toward each plan's strengths and weaknesses providing an overall assessment and evaluation of the quality of, timeliness of, and access to care and services that each health plan provides. The evaluations are based on the following definitions of quality, access, and timeliness:

- **Quality**—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  Quality, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired outcomes of its enrollees through:

  - Its structural and operational characteristics.
  - The provision of services that are consistent with current professional, evidence-based knowledge.
  - Interventions for performance improvement.[3-1]
- **Access**—CMS defines "access" in the final rule at 42 CFR §438.230 as follows:

  Access, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[3-2]
- **Timeliness**—NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction,* September 2012.

[3-2] Ibid.

a situation."[3-3] NCQA further discusses the intent of this standard as being to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require timely response by the MCP—e.g., processing expedited appeals and providing timely follow-up care. The Agency for Healthcare Research and Quality (AHRQ) indicates that "timeliness is the health care system's capacity to provide health care quickly after a need is recognized."[3-4] Timeliness includes the interval between identifying a need for specific tests and treatments and receiving those services.[3-5]

While quality, access, and timeliness are distinct aspects of care, most health plan activities and services cut across more than one area. Collectively, all health plan activities and services affect the quality, access, and timeliness of care delivered to beneficiaries.

Appendix A of this report contains detailed information about the methodologies used to conduct each of the 2017 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.

AlohaCare QUEST Integration (AlohaCare QI) Results

Compliance Monitoring Review

Table 3-1 presents the standards and compliance scores for AlohaCare QI. For standards I–VI, HSAG evaluated a total of 68 elements for the CY 2017 review period. Each element was scored as *Met*, *Partially Met*, *Not Met,* or *Not Applicable* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

Table 3-1—Standards and Compliance Scores—AlohaCare QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	8	1	0	0	94%
III	Credentialing	45	34	30	4	0	11	94%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%

[3-3] National Committee for Quality Assurance. 2013 Standards and Guidelines for Accreditation of Health Plans.
[3-4] Agency for Healthcare Research and Quality. *National Healthcare Quality Report* 2007. AHRQ Publication No. 08-0040. February 2008.
[3-5] Ibid.

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# Met	# Partially Met	# Not Met	# NA	Total Compliance Score
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**68**	**63**	**5**	**0**	**11**	**96%**
	***Total # of Elements*: The total number of elements in each standard.**							
	***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *NA*.							
	***Total Compliance Score*:** The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.							

Findings

AlohaCare QI had a total compliance score of 96 percent with four of the standards scoring 100 percent: *Provider Selection, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.

Strengths

Below is a discussion of the strengths, by standard, that were identified during the compliance review.

Provider Selection: AlohaCare QI was found to be compliant with 100 percent of the *Provider Selection* standard. The health plan's policies and procedures included all the required provisions. AlohaCare QI effectively communicated to its staff and providers that members have the right to communicate with healthcare providers regarding health status, medical care, and treatment options, and they also have the right to participate in treatment decisions.

Additionally, AlohaCare QI's training materials to inform providers about managed care, the QUEST Integration program, claims, utilization management (UM), the quality program, and other health plan operations were comprehensive. AlohaCare QI provided evidence that trainings were provided in groups and in one-on-one sessions with varying frequency based on provider needs.

Finally, AlohaCare QI's compliance plan, as well as related policies and procedures, included all the required components and described AlohaCare QI's processes related to compliance training; effective communication; reporting compliance issues; and reporting suspected fraud, waste, and abuse (FWA). AlohaCare QI provided evidence of robust claims analysis and additional methods it used to detect, report, and address FWA.

Subcontracts and Delegation: AlohaCare QI was found to be compliant with 94 percent of the *Subcontracts and Delegation* standard, with only one element scoring a *Partially Met*. AlohaCare QI had effective processes for oversight of its delegates. Policies and procedures included all the required provisions. During the on-site visit, AlohaCare QI staff demonstrated electronic tracking mechanisms for tracking and ensuring ongoing monitoring and formal review. For AlohaCare QI's pharmacy benefits manager, ExpressScripts, the health plan used joint operating committee meetings to problem solve and manage the pharmacy benefits collaboratively with the delegated vendor. Except for the ExpressScripts

agreement, delegation agreement templates and delegation agreements reviewed on-site included the required provisions.

Credentialing: AlohaCare QI was found to be compliant with 94 percent of the *Credentialing* standard, with four elements scoring a *Partially Met*. AlohaCare QI had a well-defined credentialing and recredentialing program with comprehensive policies and procedures. Review of practitioner credentialing and recredentialing files on-site demonstrated timely performance of primary source verification of credentials, Drug Enforcement Administration/Controlled Dangerous Substance (DEA/CDS) certificates when applicable, and non-exclusion using NCQA-approved databases. The process for initial assessment of organizational providers met all requirements.

Review of credentialing committee meeting minutes demonstrated the process for medical director sign-off on clean files, participation of AlohaCare QI's medical director in the credentialing program, the peer review process for review of files not meeting established criteria, and the process for ensuring nondiscriminatory credentialing and recredentialing. Provider agreement templates and practitioner credentialing and recredentialing applications contained all the required information.

Quality Assessment and Performance Improvement: AlohaCare QI was found to be compliant with 100 percent of the *Quality Assessment and Performance Improvement* standard. AlohaCare QI had dedicated staff members for its quality assessment and performance improvement (QAPI) program and activities. AlohaCare QI assigned its chief medical officer as the designated physician responsible for implementation of the quality program and facilitation of the Corporate Quality Improvement Committee (CQIC) meetings. The health plan's QAPI program was led and overseen by an experienced quality improvement program director, with assistance from a full-time, Hawaii-licensed registered nurse (quality management [QM] manager); both shared responsibility for implementation of the quality program activities. The health plan's QAPI program also had active involvement and input from a behavioral health manager and a board-certified psychiatrist to advise on all behavioral health aspects of the program.

The AlohaCare QI QAPI program was supported by numerous policies, procedures, and plans that guided expectations for the care and service delivery system and provided the framework through which monitoring and improvement activities were conducted. Annually, AlohaCare QI prepared a QAPI program description, a companion QAPI workplan, and an evaluation of the previous year's quality program activities and achievements. The evaluation was goal and data driven and was very comprehensive.

The health plan also provided its UM program description, which was supported by policies and procedures. The UM program provided evidence of AlohaCare QI's ongoing monitoring of its service utilization patterns and detection of over- and underutilization.

The health plan described three current quality improvement initiatives. One was related to pharmacy practices, and one involved engaging a HEDIS process consultant. The third initiative aimed to positively impact hospital discharge planning and involved placing inpatient UM workers in a hospital setting with the highest utilization by AlohaCare QI members.

Health Information Systems: AlohaCare QI was found to be compliant with 100 percent of the *Health Information Systems* standard. During the on-site review, AlohaCare QI presented its IS infrastructure and described the IS staffing and procedures used to support data collection, integration, and reporting needs. Various reports, meeting minutes, and quality improvement initiatives, as well as staff members' interview responses, provided evidence of the health plan's ability to collect and report information on grievances and appeals, member and provider characteristics, services, UM data, and quality reporting metrics, among other data. Processes were also in place to ensure data security and member health information privacy.

The health plan described the steps it takes to ensure service data validity and completeness, including current initiatives to receive electronic medical record files from federally qualified health centers (FQHCs). AlohaCare QI regularly validates members' actual receipt of services using a 25 percent sample of paid claims, and the health plan surveys these members about the accuracy of the services listed (e.g., date, provider, and service amount/type).

AlohaCare QI had comprehensive policies and plans related to disaster planning, disaster recovery, and business continuity, and had engaged an external firm, Clearwater Compliance, to assist the health plan with its risk assessment and preparation.

Practice Guidelines: AlohaCare QI was found to be compliant with 100 percent of the *Practice Guidelines* standard. AlohaCare QI had adopted 11 clinical practice guidelines (CPGs), including behavioral health and medical topics or conditions, as well as preventive healthcare guidelines. The process for selection, adoption, dissemination, and implementation was articulated in a policy and procedure, and information provided during the desk review and interview gave further evidence that the policy and procedure was followed and that AlohaCare QI had incorporated CPGs into all aspects of its business that impacted clinical care.

AlohaCare QI used its Practitioner Advisory Committee to discuss guidelines and decide which ones to bring forward for approval, and the health plan's CQIC reviewed and formally approved the CPGs.

AlohaCare QI further stated that it had made the decision to move from internal CPG development to utilizing and adopting CPGs published by national specialty or professional groups to ensure its use of the latest in evidence-based practices from research and consensus. AlohaCare QI published a listing of all approved CPGs on its website for providers and members to access. AlohaCare QI included the CPG information in its new provider packets, and the health plan annually distributed a provider newsletter as a reminder. In addition to external dissemination to contracted providers, AlohaCare QI had implemented training for its internal staff and discussed plans to hire an in-field trainer to interface with the providers related to CPG expectations.

Areas for Improvement

Below is a discussion of the areas for improvement, by standard, that were identified during the compliance review, and subject to implementation of a CAP.

Subcontracts and Delegation: During the on-site visit, HSAG reviewed AlohaCare QI's contract with ExpressScripts. The contract was the Medco Health Solutions (Medco) contract with AlohaCare QI, as there had been no amendment acknowledging that ExpressScripts had acquired Medco in Hawaii. In addition, because it was executed prior to the current MQD health plan request for proposal (RFP) and contract, the Medco contract did not contain all the required provisions that would have needed to be contained in the health plan's subcontract. AlohaCare QI had discovered this oversight and developed a CAP during the review period. The new contract with ExpressScripts (under negotiation at the time of the compliance review) included language to equate Medco to ExpressScripts and to bind ExpressScripts to the contractual obligations articulated in the contract between Medco and AlohaCare QI. AlohaCare QI also indicated that the new contract was being negotiated to include all MQD-required subcontract provisions. ***AlohaCare QI must ensure implementation and completion of the CAP to articulate its current relationship with ExpressScripts in a current contract, including all MQD-required provisions.***

Credentialing: During pre-on-site preparation, AlohaCare QI found that it had not performed reassessment of organizational providers that were due for reassessment during the period under review. Upon discovery, AlohaCare QI developed planned corrective actions and reported that it anticipates completion of outstanding reassessments within 30 days after the 2017 compliance site visit activities. ***AlohaCare QI must implement and track corrective action activities through completion to ensure that it has revised its process or developed an effective process for reassessment of organizational providers at least every 36 months.***

HSAG's review of AlohaCare QI's organizational provider files revealed that AlohaCare QI conducted on-site reviews for nonaccredited facilities or obtained evidence that the organizational provider had been reviewed by the State or CMS. There was not, however, evidence in the files reviewed that AlohaCare QI had reviewed the relevant materials from the State or CMS survey to determine whether "the scope and content of the site visit adequately addressed AlohaCare QI's standards and criteria for participation; or that the site visit process was consistent with AlohaCare QI's process as to rigor and intensity," as stated in AlohaCare QI's policy. That is, AlohaCare QI had not followed the processes described in its policy/procedure related to accepting State or CMS reviews in lieu of its own on-site quality assessment. ***AlohaCare QI must develop a mechanism to ensure State or CMS surveys meet AlohaCare QI's criteria for on-site quality assessment and for accepting such surveys in lieu of an AlohaCare QI on-site visit for organizational providers who are not accredited.*** If AlohaCare QI chooses to accept a CMS or State survey, it must ensure that the survey meets AlohaCare QI's standards for on-site quality assessment. This can be accomplished as described in AlohaCare QI's policy, or AlohaCare QI may establish a threshold for the survey that it will accept for participation in the network (for example, a percentage score or maximum number of deficiencies allowed for participation). If AlohaCare QI chooses a mechanism other than that described in the policy, AlohaCare QI must revise the policy to reflect the process used.

The Provider Disclosure workflow described how AlohaCare QI obtains the disclosure forms during the required time frames. On-site record review demonstrated that AlohaCare QI obtained the required ownership and disclosure forms from independent practitioners at credentialing and recredentialing, and from organizational providers at initial assessment (credentialing). Files reviewed for reassessment

(recredentialing) of organizational providers did not contain evidence that AlohaCare QI obtained the required forms at recredentialing. ***AlohaCare QI must ensure that it obtains provider disclosures as identified in its contract with MQD during recredentialing of organizational providers.***

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated AlohaCare QI's IS capabilities for accurate HEDIS reporting. (Note: The call center standard [IS 6.0] was not applicable to the measures HSAG validated.) AlohaCare QI was found to be *Fully Compliant* with all IS assessment standards except IS 5.0, which was *Partially Compliant*. This demonstrated that AlohaCare QI generally had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. AlohaCare QI elected to use one standard and nine nonstandard supplemental data sources for its performance measure reporting. During the validation process of these supplemental data sources, critical and non-critical errors were discovered within four nonstandard data sources. AlohaCare QI removed and/or addressed the errors, and the data sources were approved for HEDIS 2016 measure reporting with some restrictions. All convenience samples passed HSAG's review.

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

- Regarding the integration of behavioral health data from 'Ohana, HSAG recommends that AlohaCare QI develop and implement validation strategies on these data to ensure it meets the standards related to HEDIS reporting.
- Regarding nonstandard data obtained from a clinic that maintained a diabetes registry, HSAG recommended that AlohaCare QI prepare and submit better formal documentation for this data source.
- Regarding its data integration process, AlohaCare QI should review and update its data cleaning and validation policies to ensure that complete, clean data are received from the sources before passing the files to the software vendor. The QI plan should also identify and implement appropriate data improvement strategies that increase the quality of supplemental data received for future HEDIS reporting.

All QI measures which AlohaCare QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted for the measure. Two measures received an NA designation due to small denominators—i.e., *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* and *Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase)*. AlohaCare QI experienced no enrollment complications related to properly identifying these members on the daily and monthly enrollment files. Eligibility was properly identified within the QNXT enrollment system. AlohaCare QI passed the medical record review validation (MRRV) process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- Group B: Anticipatory Guidance & Counseling—*Weight Assessment and Counseling for Nutrition* and *Physical Activity for Children/Adolescents—Counseling for Nutrition*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- Group D: Immunization & Other Screenings—*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- Group F: Exclusions—All Medical Record Exclusions

Access to Care Performance Measure Results

AlohaCare QI's Access to Care performance measure results are shown in Table 3-2. None of the rates in this domain reported a significant improvement of more than 5 percentage points. Four measures were at or above the national Medicaid 25th percentile but below the 50th percentile, and the remaining measures were below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2017.

Table 3-2—AlohaCare QI's HEDIS Results for QI Measures Under Access to Care

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	65.59%	62.04%	-3.55	★
45–64 Years	76.08%	74.27%	-1.81	★
65 Years and Older	84.82%	81.52%	-3.30	★★
Total	69.59%	66.97%	-2.62	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	94.11%	94.23%	0.12	★★
25 Months–6 Years	83.38%	81.98%	-1.40	★
7–11 Years	87.17%	85.86%	-1.31	★
12–19 Years	84.34%	83.68%	-0.66	★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	30.21%	34.41%	4.20	★★
Engagement of AOD Treatment	7.02%	9.24%	2.22	★★

2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Children's Preventive Health Performance Measure Results

AlohaCare QI's Children's Preventive Health performance measure results are shown in Table 3-3. Six of the rates in this domain reported a significant improvement of more than 5 percentage points in 2017 (*Immunizations for Adolescents* (three indicator rates) and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (three indicator rates). Additionally, four measure rates were at or above the national Medicaid 50th percentile, with two of these rates at or above the national Medicaid 75th percentile but below the 90th percentile. The remaining measure rates were below the 25th percentile except for the *Well-Child Visits in the First 15 Months of Life (0 Visits)* and *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* measures. There was one measure in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Childhood Immunization Status—Combination 3*), and AlohaCare QI did not reach the established target, the 75th percentile.

Table 3-3—AlohaCare QI's HEDIS Results for QI Measures Under Children's Preventive Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	35.28%	38.93%	3.65	★
Childhood Immunization Status				
Combination 3	64.72%	61.31%	-3.41	★
Hepatitis B	82.73%	82.97%	0.24	★
HiB	81.27%	82.48%	1.21	★
IPV	81.02%	82.24%	1.22	★
MMR	81.51%	82.48%	0.97	★
Pneumococcal Conjugate	71.53%	66.18%	-5.35	★
VZV	80.29%	81.51%	1.22	★
Immunizations for Adolescents				
Combination 1	43.55%	50.36%	6.81	★
Combination 2	—	14.11%	—	—
HPV	—	16.55%	—	—
Meningococcal	45.01%	53.04%	8.03	★
Tdap	48.66%	57.66%	9.00	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	1.70%	2.19%	0.49	★★
Six or More Well-Child Visits	65.45%	67.88%	2.43	★★★★

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
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	64.48%	65.69%	1.21	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	60.83%	80.78%	19.95	★★★★
Counseling for Nutrition—Total	50.36%	65.21%	14.85	★★★
Counseling for Physical Activity—Total	46.47%	60.34%	13.87	★★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported in those years, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Women's Health Performance Measure Results

AlohaCare QI's Women's Health performance measure results are shown in Table 3-4. Two of the rates in this domain reported a significant improvement of more than 5 percentage points (i.e., *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits* and *Timeliness of Prenatal Care)*. Two measure rates were at or above the national Medicaid 25th percentile but below the 50th percentile, and the remaining measure rates were below the 25th percentile. There were four measures in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Breast Cancer Screening, Cervical Cancer Screening, Frequency of Ongoing Prenatal Care,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*). None of AlohaCare QI's measure rates met or exceeded the established MQD Quality Strategy targets.

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

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	50.11%	49.71%	-0.40	★
Cervical Cancer Screening				
Cervical Cancer Screening	51.58%	53.77%	2.19	★★
Chlamydia Screening in Women				
16–20 Years	40.15%	41.83%	1.68	★
21–24 Years	44.65%	43.02%	-1.63	★
Total	42.35%	42.42%	0.07	★
Frequency of Ongoing Prenatal Care				
*<21 Percent of Expected Visits**	22.63%	21.41%	-1.22	★
≥81 Percent of Expected Visits	31.39%	37.23%	5.84	★
Prenatal and Postpartum Care				
Postpartum Care	51.58%	55.72%	4.14	★★
Timeliness of Prenatal Care	66.91%	72.75%	5.84	★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Care for Chronic Conditions Performance Measure Results

AlohaCare QI's Care for Chronic Conditions performance measure results are shown in Table 3-5. Two of the measure rates in this domain reported a significant improvement of more than 5 percentage points (i.e., *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *HbA1c Control (<8.0%))*. Further, only three measure rates were at or above the national Medicaid 50th percentile but below the 75th percentile (i.e., *Annual Monitoring for Members on Digoxin* and *Medication Management for People With Asthma* [two rates]). The remaining measure rates were below the 50th percentile, with the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), HbA1c Control (<7.0%), HbA1c Testing, and Medical Attention for Nephropathy* measures falling below the 25th percentile. There were eight measures[3-6] in this domain with MQD Quality Strategy targets for

[3-6] Within this domain, there are eight MQD Quality Strategy targets: *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg); Controlling High Blood Pressure*; and *Medication Management for People with Asthma* (two rates).

HEDIS 2017; however, none of AlohaCare QI's measure rates met or exceeded the established Quality Strategy targets.

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

	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentage Point Change	2017 Performance Level
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	85.01%	85.71%	0.70	★★
Annual Monitoring for Members on Digoxin	—	56.41%	—	★★★
Annual Monitoring for Members on Diuretics	84.79%	85.90%	1.11	★★
Total	84.88%	85.47%	0.59	★★
Comprehensive Diabetes Care				
Blood Pressure Control (<140/90 mm Hg)	44.89%	52.01%	7.12	★
Eye Exam (Retinal) Performed	52.01%	50.73%	-1.28	★★
HbA1c Control (<7.0%)	21.54%	22.37%	0.83	★
HbA1c Control (<8.0%)	33.03%	40.69%	7.66	★★
*HbA1c Poor Control (>9.0%)**	56.02%	52.19%	-3.83	★★
HbA1c Testing	79.20%	78.83%	-0.37	★
Medical Attention for Nephropathy	85.58%	84.49%	-1.09	★
Controlling High Blood Pressure				
Controlling High Blood Pressure	44.88%	48.18%	3.30	★★
Medication Management for People With Asthma				
Medication Compliance 50%—Total	54.25%	57.00%	2.75	★★★
Medication Compliance 75%—Total	31.80%	35.10%	3.30	★★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Behavioral Health Performance Measure Results

AlohaCare QI's Behavioral Health performance measure results are shown in Table 3-6. Of the five measure rates reported previously in 2016, two exhibited a significant improvement of more than 5 percentage points (i.e., *Antidepressant Medication Management— Effective Continuation Phase Treatment,* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*). Two of the measure rates were at or above the national Medicaid 50th percentile but below the 75th percentile, one measure rate was at or above the 25th percentile but below the 50th percentile, and the remaining three measure rates were below the 25th percentile. There is one measure in this domain with an MQD Quality Strategy target for HEDIS 2017 (i.e., *Follow-Up After Hospitalization for Mental Illness)*, and AlohaCare QI did not reach the established target, the 75th percentile.

Table 3-6—AlohaCare QI's HEDIS Results for QI Measures Under Behavioral Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	48.51%	50.28%	1.77	★★
Effective Continuation Phase Treatment	32.05%	38.47%	6.42	★★★
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	—	NA	—	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	73.85%	—	★
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
30 Days—13–17 Years	—	16.22%	—	—
30 Days—18+ Years	—	25.73%	—	—
30 Days—Total	—	25.09%	—	—
7 Days—13–17 Years	—	13.51%	—	—
7 Days—18+ Years	—	17.60%	—	—
7 Days—Total	—	17.33%	—	—
Follow-Up After Emergency Department Visit for Mental Illness				
30-Day Follow-Up	—	45.84%	—	—
7-Day Follow-Up	—	27.08%	—	—

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	39.17%	45.22%	6.05	★
7-Day Follow-Up	19.17%	23.53%	4.36	★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	42.65%	45.65%	3.00	★★★
Continuation and Maintenance Phase	—	NA	—	NA
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness**				
*Follow-up With Assigned PCP Following Hospitalization for Mental Illness*****	—	11.36%	—	—

*** Non-HEDIS state-defined measure; rates were reported using a Microsoft (MS) Excel reporting template.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*
An "NA" value indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30 cases) to report a valid rate, resulting a small denominator (NA) audit designation. It is also used to indicate when star ratings are not applicable.
A —' indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a '—' designation:
1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or if it is a measure of utilization where a comparison to a benchmark is not appropriate.

Utilization and Health Plan Descriptive Information Performance Measure Results

AlohaCare QI's Utilization and Health Plan Descriptive Information performance measure results are shown in Table 3-7. Since utilization of more or fewer services is not indicative of performance, it is inappropriate to compare these rates to national Medicaid benchmarks. Of the measure rates reported previously in 2016, few measures exhibited a significant change in performance in 2017. Moreover, the *Ambulatory Care—ED Visits per 1,000 Member Months* measure failed to meet the MQD Quality Strategy target—i.e., 90th percentile.

Table 3-7—AlohaCare QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	50.41	49.18	-1.23	★★★★
Outpatient Visits—Total	286.77	278.82	-7.95	—
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	—	50.66%	—	—
20–44 Years Subtotal Percentage—Total	—	31.04%	—	—
45–64 Years Subtotal Percentage—Total	—	15.67%	—	—
65+ Years Subtotal Percentage—Total	—	2.63%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
Maternity—Average Length of Stay—Total	2.53	2.63	0.10	—
Maternity—Days per 1,000 Member Months—Total	8.24	7.75	-0.49	—
Maternity—Discharges per 1,000 Member Months—Total	3.26	2.95	-0.31	—
Medicine—Average Length of Stay—Total	4.30	4.75	0.45	—
Medicine—Days per 1,000 Member Months—Total	14.46	15.30	0.84	—
Medicine—Discharges per 1,000 Member Months—Total	3.36	3.22	-0.14	—
Surgery—Average Length of Stay—Total	9.08	8.56	-0.52	—
Surgery—Days per 1,000 Member Months—Total	14.58	12.87	-1.71	—
Surgery—Discharges per 1,000 Member Months—Total	1.61	1.50	-0.11	—
Total Inpatient—Average Length of Stay—Total	4.81	4.95	0.14	—

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Total Inpatient—Days per 1,000 Member Months—Total	34.73	33.58	-1.15	—
Total Inpatient—Discharges per 1,000 Member Months—Total	7.22	6.79	-0.43	—
Mental Health Utilization				
Any Service—Total	8.13%	8.02%	-0.11	—
Inpatient—Total	0.41%	0.43%	0.02	—
Intensive Outpatient or Partial Hospitalization—Total	0.06%	0.06%	0.00	—
Outpatient, ED, or Telehealth—Total	7.96%	7.84%	-0.12	—
Plan All-Cause Readmissions*				
*Plan All-Cause Readmissions****	11.32%	14.37%	3.05%	★★★

** For this indicator, a lower rate indicates better performance.*
**** Measure was not available for Medicaid Interactive Data Submission System (IDSS) reporting; rates were reported using an MS Excel reporting template. The Medicare benchmark was used for the comparison to national percentile scoring.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Conclusions and Recommendations

Based on HSAG's analyses of AlohaCare QI's measure rates with comparable benchmarks, only two of AlohaCare QI's 57 measures that were comparable to national Medicaid benchmarks demonstrated performance at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile for 2017, indicating positive performance in two preventive care measures related to weight assessment and counseling for children (BMI percentile) and well-child visits during the first 15 months of life.

Conversely, most of AlohaCare QI's rates that were comparable to national benchmarks (31 of 58 rates) ranked below the national Medicaid 25th percentile in HEDIS 2017, suggesting considerable

opportunities for improvement across all domains of care. AlohaCare QI did not meet any of the MQD Quality Strategy targets for HEDIS 2017. HSAG recommends that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services* (three rates)
  - *Children and Adolescents' Access to Primary Care Practitioners* (three rates)
- Children's Preventive Care
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status* (seven rates)
  - *Immunizations for Adolescents* (three rates)
- Women's Health
  - *Breast Cancer Screening*
  - *Chlamydia Screening in Women* (three rates)
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care* (two rates)
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care* (four rates)
- Behavioral Health
  - *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Follow-Up After Hospitalization for Mental Illness* (two rates)

Validation of Performance Improvement Projects

For validation year 2017, AlohaCare QI submitted two State-mandated PIP topics for validation: *All-Cause Readmissions* and *Diabetes Care*. The *All-Cause Readmissions* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality of, timeliness of, and access to care and services. The focus of the PIP was to decrease the rate of members readmitted to the hospital within 30 days of a hospital discharge at The Queen's Medical Center. The *Diabetes Care* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality of and access to care and services. The focus of the PIP was to increase the percentage of members with diabetes seen at Waimanalo Health Center who received a diabetic eye exam. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Findings

HSAG organized and analyzed AlohaCare QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal. Table 3-8 outlines the PIP topics, final reported SMART Aim statements, and the overall validation findings for the two PIPs.

For each PIP, AlohaCare QI was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. AlohaCare QI developed a SMART Aim statement that quantified the improvement sought for each PIP. HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence, Confidence,* and *Low Confidence*.

Table 3-8—PIP Topic, SMART Aim Statements, and Confidence Levels for AlohaCare QI

PIP Topic	SMART Aim Statement	Confidence Level
All-Cause Readmissions	By December 31, 2016, reduce all-cause readmissions at The Queen's Medical Center from 13.9% to 10.9%.	*Low Confidence*
Diabetes Care	By December 31, 2016, increase the percentage of diabetic eye exams from 42% to 50% among members 18 to 75 years of age with diabetes who are seen at Waimanalo Health Center.	*High Confidence*

HSAG assigned the level of *Low Confidence* to AlohaCare QI's *All-Cause Readmissions* PIP since the SMART Aim goal was not achieved. HSAG assigned the level of *High Confidence* to the *Diabetes Care* PIP because the SMART Aim goal was achieved and sustained, and the implemented intervention could be clearly linked to the demonstrated improvement.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

All-Cause Readmissions PIP

AlohaCare QI's focus for this PIP involved identifying and testing interventions to decrease the rate of members readmitted to the hospital within 30 days of a hospital discharge at The Queen's Medical Center. The PIP did not achieve the SMART Aim of decreasing the readmission rate from 13.9 percent to 10.9 percent by December 31, 2016. Therefore, the PIP was assigned a level of *Low Confidence*. The details leading to the assigned confidence level are described below.

The health plan's rationale for selecting The Queen's Medical Center as the targeted facility for the PIP and the PIP's initial key driver diagram illustrating the content theory behind the PIP were described in

Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. AlohaCare QI implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *All-Cause Readmissions* PIP are presented in Table 3-9.

Table 3-9—AlohaCare QI's Intervention Testing for *All-Cause Readmis*sions PIP

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Follow-up with the PCP post discharge	• Member's engagement—timeliness of follow-up with the PCP. • Member's understanding of discharge instructions.	• The member is not aware of discharge instructions to follow up with PCP. • The member did not schedule a follow-up visit with the PCP.	The health plan chose to **adopt** and continue tracking the results of this intervention.
Collaboration between The Queen's Medical Center's and AlohaCare QI's TOC teams to address members' issues prior to discharge	Hospital engagement—hospital and health plan collaboration of members transitioning home.	The member's understanding of the discharge instructions, and follow-up visit with the PCP post discharge.	The health plan chose to **abandon** this intervention.

HSAG validated AlohaCare QI's *All-Cause Readmissions* PIP SMART Aim measure rates based on the SMART Aim run chart in Module 5. Table 3-10 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 3-10—AlohaCare QI's SMART Aim Measure Results for All-Cause Readmissions PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
All-cause readmissions at The Queen's Medical Center	13.9%	10.9%	13.2%*	*Low Confidence*

* This rate was achieved in June 2016. According to the SMART Aim run chart, the lowest rate achieved was 8.1 percent, which occurred in January 2016; however, since the first PIP intervention was just being implemented at that time, the rate of 8.1 percent may be a misrepresentation of the effectiveness of the intervention.

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART aim goal rates as 13.9 percent and 10.9 percent, respectively. Because the lowest readmission rate (13.2 percent) achieved in June 2016 exceeded the desired readmission rate, HSAG determined that the SMART Aim goal was not achieved. After a comprehensive review and evaluation of the health plan's PIP

documentation, HSAG assigned the *All-Cause Readmissions* PIP a level of *Low Confidence*. Improvement was not achieved for the SMART Aim measure.

Diabetes Care PIP

AlohaCare QI's PIP involved identifying and testing interventions to increase the percentage of members with diabetes seen at Waimanalo Health Center who received an annual diabetic eye exam. During the PIP, the health plan achieved the SMART Aim of increasing the percentage of members with annual diabetic eye exams at Waimanalo Health Center from 42 percent to 50 percent by December 31, 2016. Additionally, HSAG determined that the PIP was methodologically sound and that the demonstrated improvement was clearly linked to the implemented quality improvement processes. Therefore, the PIP was assigned a level of *High Confidence*. The details leading to the assigned confidence level are described below.

The health plan's rationale for selecting Waimanalo Health Center as the targeted facility for the PIP and the PIP's initial key driver diagram illustrating the content theory behind the PIP were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. AlohaCare QI implemented only one intervention, improving communication between care coordinators and team leads at Waimanalo Health Center and AlohaCare QI care coordinators, as part of this rapid-cycle *Diabetes Care* PIP. The details of the improvement processes used and the intervention tested for the *Diabetes Care* PIP are presented in Table 3-11.

Table 3-11—AlohaCare QI's Intervention Testing for *Diabetes Care* PIP

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Improving communication between care coordinators and team leads at Waimanalo Health Center and AlohaCare QI care coordinators	Provider engagement	• The member had other priorities that came up. • The member forgets to attend the eye exam appointment.	The health plan chose to **adopt** this intervention.

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HSAG validated AlohaCare QI's *Diabetes Care* PIP performance based on the rates that the health plan plotted on the SMART Aim run chart in Module 5. Table 3-12 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 3-12—AlohaCare QI's SMART Aim Measure Results for Diabetes Care PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of diabetic eye exams from among members 18 to 75 years of age with diabetes care who are seen at Waimanalo Health Center.	42.0%	50.0%	67.0%	*High Confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART Aim goal rates as 42 percent and 50 percent, respectively. The SMART Aim goal was achieved in May 2016, and all the remaining seven data points exceeded the SMART Aim goal, with the highest rate of 67 percent achieved in November 2016. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *Diabetes Care* PIP a level of *High Confidence*. The SMART Aim goal was achieved and sustained, and the implemented intervention could be clearly linked to the demonstrated improvement.

Strengths and Weaknesses

The validation findings suggest that AlohaCare QI was successful in executing the rapid-cycle *Diabetes Care* PIP processes. The health plan met the SMART Aim goal; the quality improvement processes and the intervention could be linked to the demonstrated improvement. Therefore, HSAG assigned a level of *High Confidence* to the *Diabetes Care* PIP.

For the *All-Cause Readmissions* PIP, HSAG assigned the health plan a level of *Low Confidence.* The health plan did not achieve the SMART Aim goal for this PIP; the quality improvement processes and interventions were not executed as planned and could not be linked to the improvement.

Recommendations for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the improvement strategies used must be methodologically sound and based on solid improvement science. AlohaCare QI's PIP performance suggested several areas of opportunity that applied across the various PIP topics. HSAG recommended the following for AlohaCare QI:

- Interventions being tested must be actionable changes that will likely impact the SMART Aim measure for the project.
- Anticipate resources required to effectively implement the intervention.

- Ensure that the interventions are started in a timely manner. If delays occur, the health plan may not have incurred enough data points by the SMART Aim end date.
- Provide weekly or monthly data points showing the data and progress of intervention evaluation over time.
- Ensure that the core PIP team includes analytical staff members who are involved in all data-related processes of the PIP.

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

The following is a summary of the Child CAHPS performance highlights for AlohaCare QI. The performance highlights are broken into two key areas:

- Statewide Comparisons
- NCQA Comparisons

Findings

Table 3-13 presents AlohaCare QI's results from these analyses. For the four global ratings, five composite measures, and two individual item measures, the table depicts AlohaCare QI's trended summary rates[3-7] and statistical testing results (i.e., ▲ or ▼), and the 2016 NCQA National Average.[3-8] Additionally, AlohaCare QI's overall member satisfaction ratings (i.e., star ratings) are displayed below. Caution should be used when evaluating results with less than 100 respondents (i.e., +).

Table 3-13—Child Medicaid CAHPS Results *for* AlohaCare QI

Measure	2015 Rates	2017 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	70.0%	67.3%	★★★
Rating of All Health Care	65.1%	62.5%	★★★
Rating of Personal Doctor	74.2%	73.9%	★★★★
Rating of Specialist Seen Most Often	61.1%+	67.3%+	★★★
Composite Measures			
Getting Needed Care	76.4%	82.1%	★
Getting Care Quickly	80.4%	83.8%	★
How Well Doctors Communicate	94.4%	91.9%	★★
Customer Service	77.0%	89.8% ▲	★
Shared Decision Making	85.5%+	79.7%+	—

[3-7] The child population was last surveyed in 2015; therefore, the 2017 CAHPS scores are compared to the corresponding 2015 scores.

[3-8] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

Measure	2015 Rates	2017 Rates	Star Ratings
Individual Item Measures			
Coordination of Care	89.9%+	79.5%+	★
Health Promotion and Education	80.7%	73.4% ▼	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.

Statistical Significance Note: ▲ indicates the 2017 score is statistically significantly higher than the 2015 score

▼ indicates the 2017 score is statistically significantly lower than the 2015 score

(+) indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.

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

The trend analysis of AlohaCare QI's summary measure rates revealed the following:

- AlohaCare QI scored statistically significantly higher in 2017 than in 2015 on one measure, *Customer Service*.
- AlohaCare QI scored statistically significantly lower in 2017 than in 2015 on one measure, *Health Promotion and Education*.
- AlohaCare QI scored at or above the national average on three measures: *Customer Service*, *Shared Decision Making*, and *Health Promotion and Education.*

The detailed results of the comparison to NCQA benchmarks highlighted the following:

- AlohaCare QI did not score at or above the 90th percentile on any of the measures.
- AlohaCare QI scored at or between the 75th and 89th percentiles on one measure: *Rating of Personal Doctor.*
- AlohaCare QI scored at or between the 50th and 74th percentiles on three measures: *Rating of Health Plan, Rating of All Health Care,* and *Rating of Specialist Seen Most Often*.
- AlohaCare QI scored at or between the 25th and 49th percentiles on one measure: *How Well Doctors Communicate.*
- AlohaCare QI scored below the 25th percentile on four measures: *Getting Needed Care, Getting Care Quickly, Customer Service,* and *Coordination of Care*.

In addition, an evaluation of performance of three beneficiary satisfaction Quality Strategy measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—compared to NCQA's 2017 Benchmarks and Thresholds for Accreditation[3-9] was performed for AlohaCare QI. None

[3-9] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

of the three beneficiary satisfaction Quality Strategy measures for AlohaCare QI met or exceeded the 75th percentile.

Strengths

For AlohaCare QI's child Medicaid population, only one measure met or exceeded the 75th percentile (i.e., *Rating of Personal Doctor),* and three of the measures met or exceeded the 2016 NCQA child Medicaid national average: *Customer Service*, *Shared Decision Making*, and *Health Promotion and Education*. All remaining measure rates were below the 2016 NCQA child Medicaid national averages.

Areas for Improvement

Based on a comprehensive assessment of AlohaCare QI's CAHPS results, four potential areas for improvement were identified: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Coordination of Care*. HSAG evaluated each of these areas to determine if certain CAHPS items (i.e., questions) were strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers," are driving levels of satisfaction with three of the four measures: *Getting Needed Care*, *Getting Care Quickly*, and *Coordination of Care*. Given that these measures are driving members' level of satisfaction with each of the priority areas, AlohaCare QI should consider determining whether potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-14 depicts the individual key drivers AlohaCare QI should consider focusing on for each of the potential priority areas for quality improvement.

Table 3-14—AlohaCare QI Key Drivers of Satisfaction

Getting Needed Care
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Getting Care Quickly
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Coordination of Care
Respondents reported that their child's personal doctor did not always listen to them.
Respondents reported that their child's personal doctor did not always spend enough time with them.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about AlohaCare QI's performance in providing quality, accessible, and timely healthcare and services to its members.

Conclusions

In general, AlohaCare QI's performance results illustrate mixed performance across the four EQR activities. While the compliance monitoring review activity revealed that AlohaCare QI has established an operational foundation to support the quality, access, and timeliness of care and service delivery, performance on outcome and process measures shows considerable room for improvement.

AlohaCare QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. The health plan demonstrated high compliance (i.e., 96 percent) with federal and State contract requirements for structure and operations, as well as its commitment to quality process improvement by closing all CAPs from the previous year's compliance review. However, while policies, procedures, and staff were in place to monitor performance and promote quality, access, and timeliness of care, health plan performance indicators and member satisfaction scores were generally below the national Medicaid 50th percentile.

Overall, more than three-quarters (81 percent) of AlohaCare QI's measure rates fell below the NCQA national Medicaid 50th percentile across all domains, with 53 percent of the measure rates falling below the 25th percentile. While some measures showed improvement from 2016, AlohaCare QI performance suggests several areas needing improvement including *Access to Care* and *Women's Health* domains, where 100 percent of the measures were below the 50th percentile. None of AlohaCare QI's measure rates met the MQD's Quality Strategy targets.

Similarly, AlohaCare QI's CAHPS results illustrate opportunities for improvement in members' satisfaction. While AlohaCare QI's CAHPS global ratings—*Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often*—were at or above the 50th percentile, none of the CAHPS composite or individual measures exceeded the 50th percentile. Additionally, only three measures scored at or above the national average—i.e., *Customer Service*, *Shared Decision Making*, and *Health Promotion and Education.*

The results of AlohaCare QI's PIPs indicate a need for ongoing quality improvement training of staff. Performance across the two PIPs was mixed, with the *Diabetes Care* PIP being assessed with *High Confidence* while the *All-Cause Readmissions* PIP was assessed with *Low Confidence,* failing to reach its SMART Aim goal. These results suggest that AlohaCare continues to have opportunities for improvement in executing the rapid-cycle PIP process but shows an ability to appropriately apply key quality improvement principles. HSAG recommends ongoing QI training specific to the rapid-cycle PIP process to improve results of State-mandated PIPs and addressing deficiencies to meet the MQD's overall quality strategy.

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Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

Compliance Monitoring Review

Table 3-15 presents the standards and compliance scores for HMSA QI. For standards I–VI, HSAG evaluated a total of 74 elements for the CY 2017 review period. Each element was scored as *Met*, *Partially Met*, *Not Met,* or *Not Applicable* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

Table 3-15—Standards and Compliance Scores—HMSA QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	9	0	0	0	100%
III	Credentialing	45	40	36	4	0	5	95%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**74**	**70**	**4**	**0**	**5**	**97%**

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

Total # of Applicable Elements**:** The total number of elements within each standard minus any elements that received a score of *NA*.

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

Findings

HMSA QI had a total compliance score of 97 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.

Strengths

Below is a discussion of the strengths, by standard, that were identified during the compliance review.

Provider Selection: HMSA QI was found to be compliant with 100 percent of the *Provider Selection* standard. The health plan's policies and procedures that addressed selection and retention of providers included all the required provisions, as did its provider agreement templates. HMSA QI also had robust

training materials and methods. Provider newsletters and the online Provider Resource Center (open access) included Microsoft PowerPoint presentations and articles about health plan operations and the QI program. Training presentations also included detailed information about the formulary, prior authorization requirements, available member wellness workshops and support groups, claims and billing requirements, and reminders to keep State licenses up to date. HMSA QI also provided evidence of conducting face-to-face training presentations with the option to join via webinar to maximize attendance.

HMSA QI's compliance plan, FWA policies, and training modules included all the required information, and provided evidence of an active compliance operations committee and a FWA unit that conducted frequent data mining and monitoring, as well as member service verification to detect FWA.

Subcontracts and Delegation: HMSA QI was found to be compliant with 100 percent of the *Subcontracts and Delegation* standard. The health plan reported having five delegates for the following managed care functions:

- Beacon Health—UM determinations for behavioral health service requests
- MinuteClinic facilities—credentialing of advance practice registered nurses
- CVS—pharmacy network management
- Landmark—UM determinations for occupational and physical therapy requests
- National Imaging Associates—UM determinations for imaging requests

HMSA QI provided evidence of effective oversight and monitoring of its contracted delegates. Policies and procedures, delegation agreement templates, delegation oversight committee (DOC) meeting minutes, as well as examples of completed predelegation and annual audits demonstrated that HMSA QI had effective processes in place to maintain responsibility and accountability for all delegated tasks

Credentialing: HMSA QI was found to be compliant with 95 percent of the *Credentialing* standard, with four elements scoring *Partially Met*. In general, HMSA QI demonstrated effective operational processes for credentialing and recredentialing independent practitioners. Credentialing and recredentialing policies and procedures were NCQA compliant and included all of the required provisions. HSAG's on-site review of credentialing and recredentialing records revealed timely primary source verification of all credentials, recredentialing, and exclusion searches using NCQA-approved databases.

HMSA QI also had an effective process for assessing organizational providers. HMSA queried the Office of Inspector General's (OIG's) List of Excluded Individuals and Entities (LEIE) for both the principle owners/operators as well as the name of the organization. However, while HMSA QI staff members documented these online queries in the database, they did not print and maintain a copy of the queries. HMSA QI may want to consider maintaining printouts of these queries to document that contracted organizations are not excluded from federal healthcare participation.

Policies and procedures described the processes for ensuring nondiscriminatory credentialing and recredentialing procedures were followed during the health plan's handling of both clean files and files needing review. Additionally, provider agreement templates and practitioner credentialing and recredentialing applications contained all the required provisions and information. Credentialing delegation agreements included all the required provisions, and HMSA provided evidence of predelegation audits, ongoing monitoring and oversight, as well as annual audits (formal review).

Quality Assessment and Performance Improvement: HMSA QI was found to be compliant with 100 percent of the *Quality Assessment and Performance Improvement* standard. The HMSA QI QAPI program was supported by numerous policies, procedures, and plans guiding expectations for the health plan's care and service delivery system in support of Hawaii's QI program. The documents also provided the framework through which monitoring and improvement activities were conducted. Annually, HMSA QI prepared a QAPI program description, a QAPI workplan, and an evaluation of the previous year's quality program achievements. The QM program description addressed all member populations, the scope of covered services/settings, the role of the health information system, identification mechanisms for members with special health care needs (SHCN), and the use of CPGs, among other areas.

The health plan provided evidence of both its quality committee structure and quality program staffing. The health plan also had a behavioral health medical director—the Hawaii-based Beacon medical director—whose responsibilities included advising on the behavioral health aspects of the QI program. The workplan was highly specific, with measurable goals, time frames, and responsible staff assigned to each quality improvement project. The plan was used as the basis for the health plan's annual QAPI program evaluation. The annual evaluation demonstrated use of data, trending, and measurement against goals, and included a narrative discussion of the health plan's accomplishments and any barriers to achieving goals.

The health plan also provided its UM program description as evidence of HMSA QI's ongoing monitoring of its service utilization patterns and detection of over- and underutilization. Committee minutes and on-site interview discussions provided further evidence that the health plan used these findings in its overall quality improvement program.

Health Information Systems: HMSA QI was found to be compliant with 100 percent of the *Health Information Systems* standard. The health plan presented flow charts, descriptions, and discussions during the interviews to demonstrate its IS infrastructure, IS staffing, and policies and procedures that support the health plan's data collection, integration, and reporting needs. The information provided evidence of the health plan's ability to collect and report information on grievances and appeals, member and provider characteristics, services, UM data, and quality reporting metrics, among other data. Processes were in place to ensure data security and health information privacy, and the health plan annually conducted online intranet security and privacy awareness training and testing of staff. HMSA QI also had a business continuity program in place related to disaster planning, disaster recovery, and business continuity.

Practice Guidelines: HMSA QI was found to be compliant with 100 percent of the *Practice Guidelines* standard. The health plan had a policy and procedure, Adoption and Dissemination of Clinical Practice and Preventive Health Guidelines, which provided evidence that the decision to adopt a CPG was made:

- Based on valid, reliable clinical evidence or consensus of healthcare professionals.
- In consultation with providers.
- With consideration of the needs of enrolled members.

The policy required annual review and updates to the CPGs, and it assigned responsibility to the Quality Improvement Committee (QIC). HMSA QI had numerous CPGs for medical and behavioral health conditions and for preventive care, including Asthma, Depression, Diabetes, Hypertension, and Primary Preventive Health for Children. Links to the CPGs were available to providers on the HMSA QI website through the provider portal—the Provider Resource Center and eLibrary—and reminders about the location of the online CPGs and other provider resources were periodically published in provider newsletters (HealthPro News) and an annual bulletin.

To monitor whether actual practice was consistent with the CPGs, the health plan highlighted use of its Cozeva application, a web-based health management and communication system for providers and members. In part, the application supported HMSA QI's disease management program, identifying gaps in care as compared to the CPGs, and alerting practitioners.

Areas for Improvement

Below is a discussion of the areas for improvement, by standard, that were identified during the compliance review, and subject to implementation of a CAP.

Credentialing: Although HMSA QI's credentialing documentation was well-organized, one organizational provider was reassessed past the required three-year time frame. ***HMSA QI must ensure that organizational providers are assessed at least every three years.***

Additionally, in the past, HMSA QI had used an on-site organizational assessment form, but staff members reported that the health plan had moved away from conducting its own site visits and had been accepting a CMS or State certification in lieu of HMSA QI site visits (permitted by NCQA). However, HMSA QI did not have a process to ensure that site visits conducted by CMS or the State met HMSA QI's on-site visit standards. ***If HMSA QI chooses to accept a CMS or State survey or certification in lieu of conducting an HMSA QI on-site quality assessment, the health plan must ensure that the survey meets HMSA QI's standards for on-site quality assessment.*** This can be accomplished by obtaining the content of the site visit for comparison, or HMSA QI may establish a threshold for the site visit that it will accept for participation in the network (for example, a percentage score or maximum number of deficiencies allowed).

Finally, although HMSA QI had a process to ensure that disclosures were obtained at initial contracting with a provider, it did not have a process for ensuring that the disclosure documents were obtained every three years (at time of recredentialing). HMSA QI staff members stated that at the time of recredentialing the forms are sent to the providers, but since disclosure forms are housed in a separate database and are not connected to the recredentialing process, they are not tracked to ensure receipt.

HMSA QI must develop a mechanism to track requested ownership and disclosure forms to ensure receipt every three years at the time of recredentialing.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated HMSA QI's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) HMSA QI was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that HMSA QI had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HMSA QI elected to use two standard and one nonstandard supplemental data sources for its performance measure reporting. During the validation process of these supplemental data sources, no errors were discovered within the data sources. All convenience samples passed HSAG's review.

Based on HMSA QI's data processing procedures, the auditors made two recommendations:

- HSAG suggested that HMSA QI monitor the claims volume for quality improvement and measure reporting purposes, although this did not pose any significant concerns.
- In review of the medical record review process, the auditors noted that HMSA QI experienced challenges with obtaining medical records from some providers. As such, HSAG recommended that HMSA QI's Provider Relations department work with its HEDIS medical record team to develop better medical record procurement strategies. A more efficient process may require capturing a copy of the medical records in house for HMSA QI to meet NCQA's MRRV timeline.
- Although HMSA QI was responsive and provided appropriate feedback and clarification, responses to the preliminary rate review and several items requested in the IS Grid were provided late. HMSA QI should review its internal HEDIS processes to ensure timely responses to auditor requests.

All QI measures which HMSA QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted for the measure. One measure received an *NA* designation due to a small denominator—i.e., *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia*. HMSA QI experienced no enrollment complications related to properly identifying these members on the daily and monthly enrollment files. Eligibility was properly identified within its enrollment system. HMSA QI passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- Group B: Anticipatory Guidance & Counseling—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- Group D: Immunization & Other Screenings—*Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*

Access to Care Performance Measure Results

HMSA QI's Access to Care performance measure results are shown in Table 3-16. None of the rates in this domain reported a significant improvement of more than 5 percentage points. Overall, six of the 10 measures under Access to Care met or exceeded the national Medicaid 50th percentile, with two measure rates at or above the national Medicaid 75th percentile but below the 90th percentile, and four measure rates above the 50th percentile but below the 75th percentile. All rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure were below the 50th percentile, with three measure rates falling below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2017.

Table 3-16—HMSA QI's HEDIS Results for QI Measures Under Access to Care

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	74.54%	71.43%	-3.11	★
45–64 Years	83.48%	82.37%	-1.11	★
65 Years and Older	87.88%	87.07%	-0.81	★★
Total	77.79%	75.68%	-2.11	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	96.52%	97.50%	0.98	★★★★
25 Months–6 Years	91.01%	89.48%	-1.53	★★★
7–11 Years	93.34%	92.12%	-1.22	★★★
12–19 Years	91.05%	90.13%	-0.92	★★★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	36.77%	38.10%	1.33	★★★
Engagement of AOD Treatment	15.92%	16.38%	0.46	★★★★

2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Children's Preventive Health Performance Measure Results

HMSA QI's Children's Preventive Health performance measure results are shown in Table 3-17. Seven of the rates in this domain reported a significant improvement of more than 5 percentage points in 2017 (*Immunizations for Adolescents* [three rates], *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* [three rates], and *Well-Child Visits in First 15 Months of Life* [one rate]). Additionally, four measure rates were at or above the national Medicaid 50th percentile, with

one measure rate at or above the 90th percentile. The remaining measures were below the 25th percentile except for the *Adolescent Well-Care Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition* measures. There was one measure in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Childhood Immunization Status—Combination 3*), and HMSA QI did not reach the established target, the 75th percentile.

Table 3-17—HMSA QI's HEDIS Results for QI Measures Under Children's Preventive Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	45.26%	46.96%	1.70	★★
Childhood Immunization Status				
Combination 3	63.02%	53.77%	-9.25	★
Hepatitis B	77.37%	70.80%	-6.57	★
HiB	85.64%	83.21%	-2.43	★
IPV	81.51%	78.59%	-2.92	★
MMR	88.08%	85.16%	-2.92	★
Pneumococcal Conjugate	72.26%	64.23%	-8.03	★
VZV	87.59%	85.40%	-2.19	★
Immunizations for Adolescents				
Combination 1	41.12%	50.12%	9.00	★
Combination 2	—	18.25%	—	—
HPV	—	20.19%	—	—
Meningococcal	44.28%	54.26%	9.98	★
Tdap	47.20%	56.20%	9.00	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	2.19%	1.67%	-0.52	★★★
Six or More Well-Child Visits	68.13%	74.72%	6.59	★★★★★
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	73.97%	73.17%	-0.80	★★★

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	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	70.07%	76.16%	6.09	★★★
Counseling for Nutrition—Total	40.88%	62.29%	21.41	★★
Counseling for Physical Activity—Total	33.82%	40.88%	7.06	★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Women's Health Performance Measure Results

HMSA QI's Women's Health performance measure results are shown in Table 3-18. None of the rates in this domain reported a significant improvement of more than 5 percentage points. Three measure rates were at or above the national Medicaid 50th percentile, *Chlamydia Screening in Women* (two rates) and *Cervical Cancer Screening*, with the *Cervical Cancer Screening* rate at or above the 75th percentile but below the 90th percentile. The remaining measures were below the 25th percentile except for the *Chlamydia Screening in Women* measure for members 21–24 years of age. There were four measures in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Breast Cancer Screening, Cervical Cancer Screening, Frequency of Ongoing Prenatal Care,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*). Only HMSA QI's *Cervical Cancer Screening* rate met or exceeded the established Quality Strategy targets.

Table 3-18—HMSA QI's HEDIS Results for QI Measures Under Women's Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	66.17%	64.90%	-1.27	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	65.94%	64.63%	-1.31	★★★★

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Chlamydia Screening in Women				
16–20 Years	56.44%	56.49%	0.05	★★★
21–24 Years	60.69%	58.81%	-1.88	★★
Total	58.54%	57.55%	-0.99	★★★
Frequency of Ongoing Prenatal Care				
*<21 Percent of Expected Visits**	27.01%	20.19%	-6.82	★
≥81 Percent of Expected Visits	25.79%	29.20%	3.41	★
Prenatal and Postpartum Care				
Postpartum Care	48.42%	50.61%	2.19	★
Timeliness of Prenatal Care	73.97%	71.05%	-2.92	★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Care for Chronic Conditions Performance Measure Results

HMSA QI's Care for Chronic Conditions performance measure results are shown in Table 3-19. Three of the measure rates in this domain reported a significant improvement of more than 5 percentage points (i.e., *Comprehensive Diabetes Control—Eye Exam (Retinal) Performed* and *HbA1c Control (<7.0%),* and *Controlling High Blood Pressure*), but only one of those rates was at or above the national Medicaid 75th percentile but below the 90th percentile. One measure rate, *Medication Compliance 75%*, was at or above the 50th percentile but below the 75th percentile while the remaining measures were below the national Medicaid 50th percentile. There were eight measures[3-10] in this domain with MQD Quality Strategy targets for HEDIS 2017; however, only one of HMSA QI's measure rates met or exceeded the established Quality Strategy targets (i.e., *Comprehensive Diabetes Control—Eye Exam (Retinal) Performed).*

[3-10] Within this domain, there are eight MQD Quality Strategy targets: *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, and Blood Pressure Control (<140/90 mm Hg); Controlling High Blood Pressure*, and *Medication Management for People with Asthma* (two rates).

Table 3-19—HMSA QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	87.53%	85.48%	-2.05	★
Annual Monitoring for Members on Digoxin	46.15%	46.58%	0.43	★
Annual Monitoring for Members on Diuretics	87.55%	84.66%	-2.89	★
Total	87.03%	84.88%	-2.15	★
Comprehensive Diabetes Care				
Blood Pressure Control (<140/90 mm Hg)	47.26%	50.91%	3.65	★
Eye Exam (Retinal) Performed	53.28%	62.04%	8.76	★★★★
HbA1c Control (<7.0%)	26.81%	32.11%	5.30	★★
HbA1c Control (<8.0%)	38.87%	42.88%	4.01	★★
*HbA1c Poor Control (>9.0%)**	51.82%	47.63%	-4.19	★★
HbA1c Testing	81.93%	85.04%	3.11	★★
Medical Attention for Nephropathy	86.86%	88.50%	1.64	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	37.71%	42.82%	5.11	★
Medication Management for People With Asthma				
Medication Compliance 50%—Total	54.98%	54.73%	-0.25	★★
Medication Compliance 75%—Total	29.34%	31.62%	2.28	★★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Behavioral Health Performance Measure Results

HMSA QI's Behavioral Health performance measure results are shown in Table 3-20. Of the six measure rates reported previously in 2016, none exhibited a significant improvement of more than 5 percentage points. Two of the measure rates were at or above the national Medicaid 50th percentile, with one measure rate at or above 75th percentile but below the 90th percentile. Of the remaining five measure rates, two were below the 25th percentile. There is one measure in this domain with an MQD Quality Strategy target for HEDIS 2017 (i.e., *Follow-Up After Hospitalization for Mental Illness)*, and HMSA QI did not reach the established target, the 75th percentile.

Table 3-20—HMSA QI's HEDIS Results for QI Measures Under Behavioral Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	48.32%	48.50%	0.18	★★
Effective Continuation Phase Treatment	32.84%	32.51%	-0.33	★
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	—	NA	—	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	69.41%	—	★
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
30 Days—13–17 Years	—	25.00%	—	—
30 Days—18+ Years	—	41.16%	—	—
30 Days—Total	—	39.90%	—	—
7 Days—13–17 Years	—	21.05%	—	—
7 Days—18+ Years	—	32.55%	—	—
7 Days—Total	—	31.65%	—	—
Follow-Up After Emergency Department Visit for Mental Illness				
30-Day Follow-Up	—	58.29%	—	—
7-Day Follow-Up	—	37.15%	—	—

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	55.95%	55.36%	-0.59	★★
7-Day Follow-Up	40.67%	36.54%	-4.13	★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	52.67%	52.00%	-0.67	★★★★
Continuation and Maintenance Phase	63.38%	60.29%	-3.09	★★★
Follow-up With Assigned PCP Following Hospitalization for Mental Illness**				
*Follow-up With Assigned PCP Following Hospitalization for Mental Illness***	—	15.46%	—	—

*** Non-HEDIS state-defined measure; rates were reported using an MS Excel reporting template.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.
A "NA" value indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30 cases) to report a valid rate, resulting a small denominator (NA) audit designation. It is also used to indicate when star ratings are not applicable.
A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:
1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Utilization and Health Plan Descriptive Information Performance Measure Results

HMSA QI's Utilization and Health Plan Descriptive Information performance measure results are shown in Table 3-21. Since utilization of more or fewer services is not indicative of performance, it is inappropriate to compare these rates to national Medicaid benchmarks. Of the measure rates reported previously in 2016, few measures exhibited a significant change in performance in 2017. However, the *Ambulatory Care—ED Visits per 1,000 Member Months* measure did meet and exceed the MQD Quality Strategy target—i.e., 90th percentile.

Table 3-21—HMSA QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	39.84	42.51	2.67	★★★★★
Outpatient Visits—Total	323.87	341.05	17.18	—
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	—	53.15%	—	—
20–44 Years Subtotal Percentage—Total	—	29.38%	—	—
45–64 Years Subtotal Percentage—Total	—	16.29%	—	—
65+ Years Subtotal Percentage—Total	—	1.18%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
Maternity—Average Length of Stay—Total	2.49	2.55	0.06	—
Maternity—Days per 1,000 Member Months—Total	7.27	6.47	-0.80	—
Maternity—Discharges per 1,000 Member Months—Total	2.92	2.53	-0.39	—
Medicine—Average Length of Stay—Total	4.60	4.92	0.32	—
Medicine—Days per 1,000 Member Months—Total	9.24	11.15	1.91	—
Medicine—Discharges per 1,000 Member Months—Total	2.01	2.27	0.26	—
Surgery—Average Length of Stay—Total	6.70	6.85	0.15	—
Surgery—Days per 1,000 Member Months—Total	6.13	6.73	0.60	—
Surgery—Discharges per 1,000 Member Months—Total	0.92	0.98	0.06	—
Total Inpatient—Average Length of Stay—Total	4.13	4.47	0.34	—

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Total Inpatient—Days per 1,000 Member Months—Total	20.37	22.35	1.98	—
Total Inpatient—Discharges per 1,000 Member Months—Total	4.93	5.00	0.07	—
Mental Health Utilization				
Any Service—Total	10.01%	10.44%	0.43	—
Inpatient—Total	0.32%	0.33%	0.01	—
Intensive Outpatient or Partial Hospitalization—Total	0.06%	0.04%	-0.02	—
Outpatient, ED, or Telehealth—Total	9.91%	10.35%	0.44	—
Plan All-Cause Readmissions				
*Plan All-Cause Readmissions****	11.71%	11.15%	-0.56%	★★★★

** For this indicator, a lower rate indicates better performance.*
**** Measure was not available for Medicaid IDSS reporting; rates were reported using an MS Excel reporting template. The Medicare benchmark was used for the comparison to national percentile scoring.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.
A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:
1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Conclusions and Recommendations

Based on HSAG's analyses of those HMSA QI's measure rates with comparable benchmarks, 14 percent of HMSA QI's measure rates (8 of 59 rates) ranked at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile for 2017, indicating positive performance for several domains, including measures related to children and adolescents' access to primary care practitioners and the treatment of alcohol and other drug dependence; follow-up care for children prescribed ADHD medication; retinal eye exams for diabetic members; well-child visits during the first 15 months of life; and screening for cervical cancer. Moreover, HMSA QI met or exceeded the MQD

Quality Strategy target for three measures in 2017: *Cervical Cancer Screening*, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed,* and *Ambulatory Care—ED Visits per 1,000 Member Months*.

Conversely, most of HMSA QI's rates that were comparable to national benchmarks ranked below the national Medicaid 25th percentile in HEDIS 2017 (26 of 59 rates), suggesting considerable opportunities for improvement across all domains of care. HSAG recommends that HMSA QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services* (three rates)
- Children's Preventive Care
  - *Childhood Immunization Status* (seven rates)
  - *Immunizations for Adolescents* (three rates)
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- Women's Health
  - *Prenatal and Postpartum Care* (two rates)
  - *Frequency of Ongoing Prenatal Care* (two rates)
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care* (one rate)
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications* (four rates)
- Behavioral Health
  - *Antidepressant Medication Management* (one rate)
  - *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Validation of Performance Improvement Projects

For validation year 2017, HMSA QI submitted Modules 4 and 5 for its two State-mandated PIP topics for validation: *All-Cause Readmissions* and *Diabetes Care***.** Both of the PIP topics addressed CMS' requirements related to quality outcomes—specifically, quality, timeliness of, and access to care and services. The focus of the *All-Cause Readmissions* PIP was to reduce the rate of readmissions within 30 days for QUEST members discharged from Queens Medical Center. The focus of the *Diabetes Care* PIP was to increase the percentage of members seen at Bay Clinic and Kalihi-Palama Health Center whose most recent HbA1c control value was less than 9. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Findings

HSAG organized and analyzed HMSA QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal.

For each PIP, HMSA QI was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. HMSA QI developed a SMART Aim statement that quantified the improvement sought for each PIP. HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence*, *Confidence*, and *Low Confidence*. Table 3-22 outlines the PIP topics, final reported SMART Aim statements, and the overall validation findings for the two PIPs.

Table 3-22—PIP Topic, SMART Aim Statements, and Confidence Levels for HMSA QI

PIP Topic	SMART Aim Statement	Confidence Level
All-Cause Readmissions	By December 31, 2016, HMSA QI aims to decrease the rate of readmission within 30 days for QUEST members discharged from The Queens Medical Center from 14.0% to 11.1%.	*Low Confidence*
Diabetes Care	By December 31, 2016, for QUEST diabetic members in the targeted population seen by Bay Clinic, Kalihi-Palama Health Center, and Kokua Kalihi Valley, increase the percentage of patients whose most recent A1c was under 9 from 40.4% to 43.3%.	*Low Confidence*

HSAG assigned the level of *Low Confidence* to HMSA QI's *All-Cause Readmissions* and *Diabetes Care* PIPs. Although the SMART Aim goal was achieved for both PIPs, the improvement was not clearly linked to the documented quality improvement processes.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

All-Cause Readmissions PIP

HMSA QI's focus for this PIP was to identify and test interventions to decrease the rate of members readmitted to the hospital within 30 days of a hospital discharge at The Queen's Medical Center. The health plan achieved the PIP's SMART Aim of decreasing The Queen's Medical Center readmissions from 14.0 percent to 11.1 percent by December 31, 2016; however, the implemented interventions could not be linked to the improvement. Therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

The health plan's rationale for selecting The Queen's Medical Center as the targeted facility for the PIP and the PIP's initial key driver diagram illustrating the content theory behind the PIP were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. HMSA QI implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *All-Cause Readmissions* PIP are presented in Table 3-23 and in the narrative below.

Table 3-23—HMSA QI's Intervention Testing for *All-Cause Readmissions* PIP

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
High-risk flag on the member's medical record to provide longitudinal information to providers on high-risk patients to underscore the need for comprehensive assessment and plan	• Hospital discharge process: comprehensiveness of the plan, and length and intensity of follow-up post discharge. • Access/convenience to community providers (geographic accessibility, convenient time of day etc.).	• The provider is only treating those members who come in. • The provider does not render the service or refer due to the provider's lack of awareness of the importance of the need.	The health plan chose to **adapt** the intervention.
HMSA QI staff co-located at The Queen's Medical Center	• Coordination of information between the inpatient facility and community provider (i.e., discharge instructions, medication reconciliation). • Access/convenience to community providers. • Timeliness of aftercare appointments.	• The provider is only treating those members who come in. • The provider does not render the service or refer due to the provider's lack of awareness of the importance of the need.	The health plan chose to **adopt** this intervention.

HSAG validated HMSA QI's *All-Cause Readmissions* PIP SMART Aim measure rates based on the SMART Aim run chart in Module 5. Table 3-24 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 3-24—HMSA QI's SMART Aim Measure Results for All-Cause Readmissions PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
The percentage of readmissions within 30 days for QUEST members discharged from The Queens Medical Center.	14.0%	11.1%	6.1%	*Low Confidence*

On the final SMART Aim measure run chart, the lowest readmission rate of 6.1 percent was achieved in August 2016. HSAG determined that the SMART Aim goal was achieved. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *All-Cause Readmissions* PIP a level of *Low Confidence*. Although the SMART Aim goal was achieved, the improvement was not clearly linked to the documented quality improvement processes. The health plan documented that it needed additional time to test the interventions for effectiveness.

Diabetes Care PIP

The focus of HMSA QI's *Diabetes Care* PIP was to identify and test interventions to increase the percentage of diabetic patients whose most recent HbA1c was less than 9 and who were seen at Bay Clinic, Kalihi-Palama Health Center, and Kokua Kalihi Valley. The health plan achieved the PIP's SMART Aim goal of increasing the percentage of patients whose most recent HbA1c was less than 9 to 43.3 percent; however, the implemented intervention could not be linked to the improvement. Therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below

The health plan's rationale for selecting its provider focus for the PIP, and the PIP's initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. The details of the improvement processes used and the interventions tested for the *Diabetes Care* PIP are presented in Table 3-25.

Table 3-25—HMSA QI's Intervention Testing for *Diabetes Care* PIP

Intervention	Key Drivers Addressed	Failure Mode Addressed	Conclusions
Diabetes depiction	• Provider: Tracking mechanism • Treatment/medication intensification	• Patient's medication regimen is not advanced according to guidelines • Provider engagement	The health plan chose to **abandon** the intervention.
CM [case management] adherence	Medication adherence	Patient's medication-taking diminishes and stops because the patient does not understand the reason for the medication.	Not applicable: The health plan implemented the intervention in December 2016.

Intervention	Key Drivers Addressed	Failure Mode Addressed	Conclusions
SMS [short message service] adherence messaging	Medication adherence	Patient's medication-taking diminishes and stops because the patient does not understand the reason for the medication.	Not applicable: The health plan did not implement the intervention.

HSAG validated HMSA QI's *Diabetes Care* PIP performance based on the rates that the health plan plotted on the SMART Aim run chart in Module 5. Table 3-26 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 3-26—HMSA QI's SMART Aim Measure Results for Diabetes Care PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of diabetic patients whose most recent A1c was under 9 and who were seen at Bay Clinic, Kalihi-Palama Health Center, and Kokua Kalihi Valley.	40.4%	43.3%	61.7%	*Low Confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART Aim goal rates as 40.4 percent and 43.3 percent, respectively. The SMART Aim goal was achieved, with the highest rate of 61.7 percent occurring in May 2016. The final SMART Aim measure rate in December 2016 was 55 percent. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *Diabetes Care* PIP a level of *Low Confidence*. Although the SMART Aim goal was achieved, the improvement was not clearly linked to the documented quality improvement processes.

Strengths and Weaknesses

The validation findings suggest that even though HMSA QI met the SMART Aim goal for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. Additionally, the health plan documented that it needed additional time to test the interventions for effectiveness. Therefore, HSAG assigned a level of *Low Confidence* to both PIPs.

Recommendations for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the improvement strategies used must be methodologically sound and based on solid improvement science. HMSA QI's PIP performance suggested several areas of opportunity that applied across the various PIP topics. HSAG recommended the following for HMSA QI:

- Ensure that the interventions are started in a timely manner. If delays occur, the health plan may not have incurred enough data points by the SMART Aim end date.
- Ensure that the core PIP team includes analytical staff members who are involved in all data-related processes of the PIP.
- Consider testing interventions in multiple environments before adoption.

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

The following is a summary of the Child CAHPS performance highlights for HMSA QI. The performance highlights are broken into two key areas:

- Statewide Comparisons
- NCQA Comparisons

Findings

Table 3-27 presents HMSA QI's results from these analyses. For the four global ratings, five composite measures, and two individual item measures, the table depicts HMSA QI's trended summary rates[3-11] and statistical testing results (i.e., ▲ or ▼), and the 2016 NCQA National Average.[3-12] Additionally, HMSA QI's overall member satisfaction ratings (i.e., star ratings) are displayed below. Caution should be used when evaluating results with less than 100 respondents (i.e., +).

Table 3-27—Child Medicaid CAHPS Results *for* HMSA QI

Measure	2015 Rates	2017 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	74.3%	73.6%	★★★★
Rating of All Health Care	69.6%	69.8%	★★★★★
Rating of Personal Doctor	76.7%	74.6%	★★★★
Rating of Specialist Seen Most Often	74.6%+	72.6%+	★★★★
Composite Measures			
Getting Needed Care	84.5%	87.0%	★★★
Getting Care Quickly	87.7%	91.0%	★★
How Well Doctors Communicate	94.0%	95.4%	★★★★
Customer Service	91.8%	87.7%	★
Shared Decision Making	79.0%+	80.6%+	—

[3-11] The child population was last surveyed in 2015; therefore, the 2017 CAHPS scores are compared to the corresponding 2015 scores.

[3-12] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

Measure	2015 Rates	2017 Rates	Star Ratings
Individual Item Measures			
Coordination of Care	88.2%	84.4%+	★★
Health Promotion and Education	70.2%	77.3% ▲	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.

Statistical Significance Note: ▲ indicates the 2017 score is statistically significantly higher than the 2015 score

▼ indicates the 2017 score is statistically significantly lower than the 2015 score

(+) indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.

Star Ratings based on percentiles:

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

The trend analysis of HMSA QI's summary measure rates revealed the following:

- HMSA QI scored statistically significantly higher in 2017 than in 2015 on one measure, *Health Promotion and Education*.
- HMSA QI scored at or above the national average on nine measures: *Rating of Health Plan*, *Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education.*

The detailed results of the comparison to NCQA benchmarks highlighted the following:

- HMSA QI scored at or above the 90th percentile on one measure: *Rating of All Health Care*.
- HMSA QI scored at or between the 75th and 89th percentiles on four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate.*
- HMSA QI scored at or between the 50th and 74th percentiles on one measure: *Getting Needed Care.*
- HMSA QI scored at or between the 25th and 49th percentiles on two measures: *Getting Care Quickly* and *Coordination of Care.*
- HMSA QI scored below the 25th percentile on one measure: *Customer Service.*

In addition, an evaluation of performance of three beneficiary satisfaction Quality Strategy measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—compared to NCQA's 2017 Benchmarks and Thresholds for Accreditation[3-13] was performed for HMSA QI. Only

[3-13] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

two of the beneficiary satisfaction Quality Strategy measures for HMSA QI met or exceeded the 75th percentile goal (i.e., *Rating of Health Plan* and *How Well Doctors Communicate*); the *Getting Needed Care* composite measure did not.

Strengths

For HMSA QI's child Medicaid population, five of the measures met or exceeded the 75th percentile (i.e., *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate),* and nine of the measures met or exceeded the 2016 NCQA child Medicaid national average: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*. Only two measure rates did not meet the 2016 NCQA child Medicaid national averages.

Areas for Improvement

Based on a comprehensive assessment of HMSA QI's CAHPS results, three potential areas for improvement were identified: *Customer Service*, *Getting Care Quickly*, and *Coordination of Care*. HSAG evaluated each of these areas to determine if certain CAHPS items (i.e., questions) are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers" are driving levels of satisfaction with each of the three measures. Given that these measures are driving members' level of satisfaction with each of the priority areas, HMSA QI should consider determining whether potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-28 depicts the individual key drivers HMSA QI should consider focusing on for each of the potential priority areas for quality improvement.

Table 3-28—HMSA QI Key Drivers of Satisfaction

Customer Service
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.
Getting Care Quickly
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Coordination of Care
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.
Respondents reported that their child's personal doctor did not always spend enough time with them.
Respondents reported that a doctor or other health provider did not always talk to them about specific things they could do to prevent illness in their child.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about HMSA QI's performance in providing quality, accessible, and timely healthcare and services to its members.

Conclusions

In general, HMSA QI's performance results illustrates mixed performance across the four EQR activities. While the compliance monitoring review activity revealed that HMSA QI has established an operational foundation to support the quality, access, and timeliness of care and service delivery, performance on outcome and process measures shows room for improvement.

HMSA QI's compliance review showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. The health plan demonstrated high compliance (i.e., 97 percent) with federal and State contract requirements for structure and operations, as well as its commitment to quality process improvement by closing all CAPs from the previous year's compliance review. However, while policies, procedures, and staff were in place to monitor performance and promote quality, access, and timeliness of care, health plan performance indicators and member satisfaction scores were often below the national Medicaid 50th percentile.

Overall, more than half (66 percent) of HMSA QI's measure rates fell below the NCQA national Medicaid 50th percentile across all measurement domains, with 44 percent of the measure rates falling below the 25th percentile. While some measure rates showed improvement from 2016, HMSA QI's performance suggested several areas of improvement including the *Children's Preventive Care*, *Care for Chronic Conditions*, and *Behavioral Health* domains, where more than 70 percent of the measure rates failed to meet the 50th percentile. Overall, only three of the measure rates met the MQD's Quality Strategy targets.

Conversely, HMSA QI's CAHPS results suggest strong satisfaction among its members as all global ratings were at or above the 75th percentile. Moreover, HMSA QI scored at or above the national average on nine measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education.* HMSA QI met or exceeded two of the three MQD Quality Strategy targets for beneficiary satisfaction.

The results of HMSA QI's PIPs indicate a need for ongoing quality improvement training of staff. Performance across the two PIPs showed considerable opportunity for improvement in implementing the PIPS—i.e., *Diabetes Care* and *All-Cause Readmissions.* Both PIPs were assessed as *Low Confidence.* While the validation findings determined that HMSA QI met the SMART Aim goals for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. These results suggest that HMSA QI continues to have opportunities for improvement in executing the rapid-cycle PIP process. HSAG recommends ongoing QI training specific to the rapid-cycle PIP process to improve the results of State-mandated PIPs.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

Compliance Monitoring Review

Table 3-29 presents the standards and compliance scores for KFHP QI. For standards I–VI, HSAG evaluated a total of 68 elements for the CY 2017 review period. Each element was scored as *Met*, *Partially Met*, *Not Met*, or *Not Applicable* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

Table 3-29—Standards and Compliance Scores—KFHP QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	3	4	2	0	56%
III	Credentialing	45	34	27	6	1	11	88%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**68**	**55**	**10**	**3**	**11**	**88%**

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

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

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

Findings

KFHP QI had a total compliance score of 88 percent with four of the standards scoring 100 percent: *Provider Selection*, *Quality Assessment and Performance Improvement*, *Health Information Systems*, and *Practice Guidelines*. Three elements across the *Subcontracts and Delegation* and *Credentialing* standards were noncompliant.

Strengths

Below is a discussion of the strengths, by standard, that were identified during the compliance review.

Provider Selection: KFHP QI was found to be compliant with 100 percent of the *Provider Selection* standard. The health plan demonstrated that it used the provider manual to communicate to providers about members' rights to participate in care decisions and receive information about treatments (including alternative treatments), benefits, and risks of treating or not treating. Additionally, the

provider agreement for KFHP QI's affiliated providers (non-Kaiser practitioners) and the service agreement between KFHP QI and the Hawaii Permanente Medical Group (HPMG) required the contracted entities to comply with the provider manual.

KFHP QI had provider orientation presentations that included an array of information about the health plan including health plan operations, organizational structure, QUEST Integration benefit packages, grievance and appeal processes, disease management, other member programs, and coding procedures to ensure accurate HEDIS data. The Provider Education policy described the process for ensuring face-to-face education sessions are conducted every six months and offered via WebEx for those who choose to participate remotely or access the training later.

KFHP QI's compliance plan was comprehensive and addressed each of the required provisions.

Subcontracts and Delegation: KFHP QI was found to be compliant with only 56 percent of the *Subcontracts and Delegation* standard, with four elements scoring a *Partially Met* and two elements scoring a *Not Met*. KFHP QI initially reported no delegation subcontracts or delegated activities; however, after review of the KFHP QI provider directory, HSAG found that the health plan delegates pharmacy benefits management (PBM) to MedImpact. Further, during on-site document review and discussions, HSAG identified that KFHP QI, the Kaiser Foundation Hospital (KFH), and HPMG are separate entities with independent management under federal and State laws and regulations, and independent accreditation standards; each entity has its own self-governance documents.

KFHP QI provided detailed evidence of effective, ongoing monitoring and formal review of both MedImpact and HPMG to satisfy the requirement that KFHP QI oversees and is accountable for any functions and responsibilities delegated to its subcontractors. Policies, procedures, and on-site discussions provided evidence that KFHP QI has processes to submit any new delegation agreements to MQD for review and approval should KFHP QI plan to enter into new delegation arrangements.

The MedImpact Service Agreement specified the activities delegated to the respective subcontractor and delineated the required reports. Both the MedImpact Service Agreement and the HPMG Medical Service Agreement provided for corrective action, sanctions, or for revoking the agreement if the delegate's performance was inadequate.

Credentialing: KFHP QI was found to be compliant with only 88 percent of the *Credentialing* standard, with six elements scoring *Partially Met* and one element scoring a *Not Met*. Overall, KFHP QI had effective operational processes for credentialing and recredentialing independent practitioners. Credentialing and recredentialing policies and procedures included most of the requirements and were designed to comply with NCQA standards and guidelines. On-site review of individual practitioner credentialing and recredentialing records revealed timely primary source verification of all credentials, recredentialing, and exclusion searches using NCQA-approved databases. Review of credentialing committee meeting minutes demonstrated the peer review process for review of files not meeting established criteria, and the process for ensuring nondiscriminatory credentialing and recredentialing decisions. Practitioner credentialing and recredentialing applications contained all the required information.

Quality Assessment and Performance Improvement: KFHP QI was found to be compliant with 100 percent of the *Quality Assessment and Performance Improvement* standard. KFHP QI had a local QM leadership team structure that included its subcontractor/partner organization, HPMG. The health plan's QAPI program had active involvement and input from a variety of HPMG practitioners, including behavioral health and other board-certified specialists.

The quality program was supported by numerous policies, procedures, and plans that guided expectations for the care and service delivery system and provided the framework through which monitoring and improvement activities were conducted. The Kaiser Permanente 2017 Quality Program Description—Hawaii Region was approved in March 2017 and included the strategic priorities and quality objectives, program authority, roles/responsibilities, and committee descriptions. Annually, Kaiser Permanente (the health plan, medical group, and hospital) prepared a comprehensive, integrated QAPI program description, a companion workplan, and an evaluation of the previous year's quality program activities and achievements.

The health plan also provided its UM program description and provided evidence of ongoing monitoring of KFHP QI's service utilization patterns and detection of over- and underutilization.

Health Information Systems: KFHP QI was found to be compliant with 100 percent of the *Health Information Systems* standard. During the on-site review, KFHP QI staff members presented the infrastructure of the health plan's integrated health information system, Epic, and described the procedures used to support data collection, integration, and reporting needs. Various reports, flow diagrams, meeting minutes, as well as staff members' interview responses provided evidence of the health plan's ability to collect and report information on grievances and appeals, member and provider characteristics, services, UM data, and quality reporting metrics, among other data. The health plan had recently transitioned from an International Business Machines Corp. (IBM) Lotus Notes application for grievance and appeal data capture and reporting to a new application known as CIWRS.

The health plan described the steps it takes to ensure service data validity and completeness, especially for its claims and encounters information. Tapestry, the claims system, was used to translate internal providers' service encounters into claims, and the KP ClaimsConnect system served as the health plan's repository for service data mining. In addition to a series of claims edits, KFHP QI used a process to validate actual receipt of services by members, matching external provider referrals to explanation of benefits forms and using its service coordinators' interface with members to ensure the members had received the planned services.

Processes were in place to ensure data security and member health information privacy, and staff training was provided regarding Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and confidentiality of protected health information. KFHP QI also had national- and regional-level policies and plans related to disaster planning, disaster recovery, and business continuity. The health plan had internal emergency operations protocols and had provided staff training and conducted exercises of response procedures.

Practice Guidelines: KFHP QI was found to be compliant with 100 percent of the *Practice Guidelines* standard. KFHP QI had adopted several national-level CPGs and nine local Hawaii Region CPGs. The

process for selection, adoption, dissemination, and implementation was articulated in a policy and procedure and incorporated into the program descriptions for both quality and UM. KFHP QI reviews and revises, as needed, its CPGs every two years and has a tracking schedule for this process.

The health plan had processes for regular dissemination of CPG information to providers, including use of an online clinical library. CPG information was available on the Kaiser Permanente website provider portal, incorporated into member educational materials, and was also used in the applicable disease management programs. KFHP QI provided evidence that the policy and procedure were followed and had incorporated CPGs into all aspects of its business that impacted clinical care. KFHP QI had adopted several national-level CPGs and nine local Hawaii Region CPGs.

Areas for Improvement

Below is a discussion of the areas for improvement, by standard, that were identified during the compliance review, and subject to implementation of a CAP.

Subcontracts and Delegation: KFHP QI initially reported no delegation subcontracts or delegated activities; however, after review of the KFHP QI provider directory, HSAG found that the health plan delegates PBM to MedImpact. The delegated duties of MedImpact included claims management and network management of two non-Kaiser pharmacies serving Medicaid members. KFHP QI reported this to be a national contract relationship and provided evidence that the relationship between the health plan's Hawaii region and the MedImpact Hawaii regional organization was articulated in an addendum to the national agreement to recognize the local relationship and authority.

Additionally, during on-site document review and discussions, HSAG and KFHP QI explored the concepts found in Kaiser's organizational structure documents and agreements between KFHP QI and HPMG and between KFHP QI and the Kaiser Foundation Hospital (KFH). Documents reviewed and on-site discussions with Kaiser staff members delineated KFHP QI, HPMG, and KFH as separate entities with independent management under federal and State laws and regulations, and independent accreditation standards; each entity has its own self-governance documents. Kaiser's submitted documentation also stated that KFHP QI has a formal contract with HPMG for the provision of services and certain administrative functions related to its Medicaid managed care contract with MQD. Based on these documents and on-site discussions, HSAG determined that KFHP QI delegates provider network development and management to HPMG (i.e., determination of when hiring or contracting with additional physicians is necessary and the activities associated with recruiting, hiring [or contracting when necessary], and training those physicians). HSAG also determined that a portion of UM is delegated to HPMG (i.e., prior authorization/denial of certain service requests and appeal determinations when a physician is required for the determination), as HPMG employs or contracts with all physicians necessary to provide medical services to the health plan.

KFHP QI did not have a policy, procedure, or process to notify the Department of Human Services (DHS) if a subcontractor providing administrative services is terminated and that termination would materially affect the health plan's ability to fulfill the terms of Kaiser's contract with MQD. ***KFHP QI must develop a mechanism to notify DHS in writing at least 90 days prior to adding or deleting***

subcontractor agreements or making any change to any subcontractor agreements that may materially affect the health plan's ability to fulfill the terms of the contract.

KFHP QI's MedImpact Service Agreement (or the business associate agreement [BAA] as applicable):

- Did not contain language that the delegate agrees to meet the criteria and provide services as specified in the health plan's contract with MQD.
- Did not provide the required information regarding the member grievance system (42 CFR §438[g][2][xi]).
- Did not contain the required hold harmless and liability for payment language required by federal Medicaid regulations and the MQD contract.
- Did not contain the requirement to follow all audit requirements outlined in the Medicaid managed care contract.
- Did not include a requirement for tracking and reporting complaints to the health plan.
- Required MedImpact to adhere to privacy and confidentiality regulations and to report breaches; however, the time frame for reporting was stated as five business days, and there were no requirements for a written report within 30 business days following an investigation.
- Required maintenance of records for three years; however, the MQD contract requires records to be maintained for seven years.

KFHP QI must amend its current agreement with MedImpact or develop an additional contract, agreement, or memorandum of understanding (MOU) with MedImpact to:

- Include language that the delegate agrees to meet the criteria and provide services as specified in the health plan's contract with MQD.
- Include all required information about the Medicaid member grievance system or bind MedImpact to a document containing the required components of the Medicaid member grievance and appeal system (refer to 42 CFR §438.414).
- Include the required hold harmless/liability for payment language required by federal Medicaid regulations and the MQD contract.
- Include the requirement to follow all audit requirements outlined in the Medicaid managed care contract.
- Include the requirement for MedImpact to track and report complaints about MedImpact to the health plan.
- Revise the contractual reporting time frame to MQD for discovery of confidentiality breaches to two business days and include a requirement that the subcontractor is required to submit a written report of its investigation and mitigation within 30 business days of the discovery.
- Include a provision that the subcontractor must retain medical records in compliance with the State's health plan contract.

The Medical Service Agreement between KFHP QI and HPMG:

- Did not state that any specific tasks were delegated and did not specify activities associated with the administrative tasks delegated to HPMG (i.e., tasks related to assessing access and availability to determine network needs, hiring, and contracting with practitioners; and tasks associated with review and determination of service utilization and appeal requests when physicians are required for those decisions).
- Did not contain a requirement for HPMG to track and report complaints about HPMG to the health plan.
- Required both entities to maintain confidentiality to the extent required by State and federal law; however, the agreement contained no requirement for reporting breaches of confidential information within the required time frame or for submitting the written report within 30 business days following an investigation.

***KFHP QI must amend the current, written Medical Service Agreement with HPMG or develop an additional contract, agreement, or MOU to*:**

- Specify the activities and reporting responsibilities associated with the delegated tasks related to provider network development and management, and utilization review (UR) and appeal determinations.
- Require the medical group to track and report complaints against itself to the health plan.
- Include the provision for HPMG to report any breaches of confidentiality within two business days and to submit a written report of its investigation and mitigation within 30 business days of the discovery.

Additionally, during the review, KFHP QI noted that several contracts, subcontracts, and agreements were "sensitive" and required redaction prior to inspection and/or were limited to on-site inspection only. Moreover, there were inconsistencies noted in some of the documents, making verification of the completeness and accuracy of the versions difficult. ***In accordance with MQD RFP–MQD–2014-005, Section 71.800 and Section 71.900, health plans must provide unrestricted access to all records without undue delay. KFHP QI must amend its current operational procedures to ensure compliance with future requests to inspect and audit any records related to KFHP QI's Medicaid operations in Hawaii.*** The updated P&P should be submitted to the MQD for review and approval, and must submit a complete set of subcontracts for MQD review as part of its CAP, including but not limited to, the service agreements/contracts with MedImpact Healthcare Systems, Inc., Kaiser Permanente Medical Group, and Kaiser Permanente Hospital Group.

Credentialing: The Credentialing and Privileging policy included aspects of the process to delegate credentialing activities; however, it did not include which credentialing activities may be delegated, how the organization decides to delegate, or whether the health plan delegates credentialing. ***KFHP QI must revise its policies and procedures that address credentialing to include which credentialing activities may be delegated, how the organization decides to delegate, and whether the health plan delegates credentialing.***

HSAG HEALTH SERVICES ADVISORY GROUP

Although the Credentialing and Privileging policy and procedure adequately addressed the requirement to notify practitioners within 60 days of the credentialing decision, the on-site record review included two files in which the letter was sent beyond the 60-calendar-day time frame. ***KFHP QI must develop a mechanism to track and monitor practitioners' notification of the credentialing decision within 60 calendar days of the committee's decision.***

The Credentialing and Privileging policy was unclear as to the medical director's or designee's responsibility and participation in the credentialing program or committee. ***KFHP QI must revise its policies and procedures that address credentialing and recredentialing to specify the medical director's (or designee's) responsibilities and participation in the credentialing program or committee.***

The Credentialing and Privileging policy addressed the requirement to assess organizational providers before contracting and every three years thereafter. The policy also stated that, for QUEST Integration providers, the time frame was every two years. KFHP QI may want to consider aligning the requirements for QUEST Integration providers with NCQA guidelines and the health plan's practices (every three years). One of the organizational provider files reviewed on-site showed a reassessment (recredentialing) date approximately five months past the due date if following a three-year cycle, or one year and five months past the due date if following a two-year reassessment cycle as stated in policy. In addition, several organizational provider files did not contain evidence of obtaining a copy of the license from the organization or otherwise ensuring that the organization was in good standing with the State licensing agency. ***KFHP QI must develop a mechanism to track and monitor the health plan's confirmation that organizational providers are in good standing with State regulatory agencies. KFHP QI must also develop a mechanism to ensure that the reassessment of organizational providers occurs in a timely manner and according to policy (every two years) or revise and follow the policy to conform with NCQA's standard of reassessment of at least every three years.***

The Credentialing and Privileging policy included the process for the health plan to conduct site visits for nonaccredited organizational providers; however, it did not address whether KFHP QI would accept a CMS or State survey in lieu of its own site review, and if so, the process for doing so. The on-site record review revealed that KFHP QI did not perform its own site visit and did accept State or CMS surveys in lieu of a site visit; however, KFHP QI's receipt of the report (or a letter) was inconsistent. HSAG saw no evidence that KFHP QI evaluated the report from the State licensing agency to ensure it met the health plan's standards. ***KFHP QI must develop a mechanism to ensure State or CMS surveys meet the health plan's criteria for on-site quality assessment and for accepting such survey in lieu of a KFHP QI on-site visit for organizational providers that are not accredited.*** If KFHP QI chooses to accept a CMS or State survey, it must ensure that the survey accepted in lieu of a site visit meets the health plan's standards for on-site quality assessment by comparing the CMS or State survey to KFHP QI's site visit form or establishing a threshold for the survey that KFHP QI will accept for participation in the network (for example, a percentage score or maximum number of deficiencies allowed).

Of the sample of organizational provider credentialing and recredentialing records reviewed on-site, the only provider disclosure information for which the health plan was unable to provide evidence was the documentation for KFH (a contracted organizational provider). ***KFHP QI must ensure that KFH is***

subject to tracking and that the organization submits ownership and disclosure documents every three years.

The Medical Service Agreement between KFHP QI and HPMG did not include provisions for submitting ownership and disclosure documents to the health plan. ***KFHP QI must amend its current agreement with HPMG or develop an additional contract, agreement, or MOU to ensure that HPMG complies with the requirements to submit provider ownership and disclosure forms.***

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated KFHP QI's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) KFHP QI was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that KFHP QI had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. KFHP QI 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, errors were discovered within one of the nonstandard data sources. KFHP QI removed the errors, and the data sources were approved for HEDIS 2016 measure reporting. All convenience samples passed HSAG's review.

All QI measures which KFHP QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted for the measure. Four measure rates received an *NA* designation due to a small denominator—i.e., *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (7-Day Follow-up [3–17 Years] and 30-Day Follow-up [3–17 Years]),* and *Follow-Up Care for Children Prescribed ADHD Medication (Continuation and Maintenance Phase)*. KFHP QI experienced no enrollment complications related to properly identifying these members on the daily and monthly enrollment files. Eligibility was properly identified within its enrollment system. KFHP QI passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Controlling High Blood Pressure*
- Group B: Anticipatory Guidance & Counseling—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*
- Group D: Immunization & Other Screenings— *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- Group F: Exclusions—*All Medical Record Exclusions*

Access to Care Performance Measure Results

KFHP's Access to Care performance measure results are shown in Table 3-30. While none of the rates in this domain reported a significant improvement of more than 5 percentage points, three measure rates exceeded the 90th percentile (i.e., *Adults' Access to Preventive/Ambulatory Health Services [65 Years and Older]* and *Children and Adolescents' Access to Primary Care Practitioners [12–24 Months* and *25 months–6 Years]*) and one measure rate was at or above the 75th percentile but below the 90th percentile. Only three measure rates were below the national Medicaid 50th percentile There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2017.

Table 3-30—KFHP QI's HEDIS Results for QI Measures Under Access to Care

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	80.55%	77.10%	-3.45	★★
45–64 Years	86.51%	85.34%	-1.17	★★
65 Years and Older	92.51%	95.07%	2.56	★★★★★
Total	83.10%	80.83%	-2.27	★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	99.07%	98.40%	-0.67	★★★★★
25 Months–6 Years	95.38%	93.77%	-1.61	★★★★★
7–11 Years	93.43%	92.49%	-0.94	★★★
12–19 Years	92.34%	91.78%	-0.56	★★★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	38.94%	41.72%	2.78	★★★
Engagement of AOD Treatment	13.46%	14.69%	1.23	★★★★

2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Children's Preventive Health Performance Measure Results

KFHP QI's Children's Preventive Health performance measure results are shown in Table 3-31. While none of the rates in this domain reported a significant improvement of more than 5 percentage points in 2017, seven measures rates were at or above the 90th percentile. An additional eight measure rates were at or above the national Medicaid 50th percentile, with five of these measure rates at or above the 75th percentile but below the 90th percentile. The remaining two measures were at or above the 25th percentile but below the 50th percentile. There was one measure in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Childhood Immunization Status—Combination 3*), and KFHP QI met or exceeded the established target, the 75th percentile.

Table 3-31—KFHP QI's HEDIS Results for QI Measures Under Children's Preventive Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	44.41%	44.52%	0.11	★★
Childhood Immunization Status				
Combination 3	80.75%	79.71%	-1.04	★★★★
Hepatitis B	93.94%	93.24%	-0.70	★★★★
HiB	88.96%	90.38%	1.42	★★★
IPV	92.73%	94.02%	1.29	★★★★★
MMR	92.46%	92.72%	0.26	★★★★
Pneumococcal Conjugate	82.37%	82.18%	-0.19	★★★
VZV	90.98%	91.81%	0.83	★★★
Immunizations for Adolescents				
Combination 1	85.37%	82.66%	-2.71	★★★★
Combination 2	—	32.45%	—	—
HPV	—	33.57%	—	—
Meningococcal	86.92%	85.03%	-1.89	★★★★
Tdap	88.47%	84.48%	-3.99	★★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	0.00%	0.14%	0.14	★★★★★
Six or More Well-Child Visits	79.56%	75.04%	-4.52	★★★★★
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	87.14%	83.34%	-3.80	★★★★★

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	92.94%	94.03%	1.09	★★★★★
Counseling for Nutrition—Total	97.57%	98.51%	0.94	★★★★★
Counseling for Physical Activity—Total	97.57%	97.01%	-0.56	★★★★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Women's Health Performance Measure Results

KFHP QI's Women's Health performance measure results are shown in Table 3-32. While only one of the rates in this domain reported a significant improvement of more than 5 percentage points, all the measure rates were at or above the 75th percentile. Moreover, six of the measure rates were above the 90th percentile (i.e., *Breast Cancer Screening, Cervical Cancer Screening, Frequency of Ongoing Care* [two rates], and *Prenatal and Postpartum Care* [two rates]). There were four measures in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Breast Cancer Screening, Cervical Cancer Screening, Frequency of Ongoing Prenatal Care,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*), and KFHP QI met or exceeded the established Quality Strategy targets of all measures.

Table 3-32—KFHP QI's HEDIS Results for QI Measures Under Women's Health

	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentage Point Change	2017 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	81.55%	75.87%	-5.68	★★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	81.27%	76.80%	-4.47	★★★★★

	HEDIS 2016 Rate	HEDIS 2017 Rate	Percentage Point Change	2017 Performance Level
Chlamydia Screening in Women				
16–20 Years	68.05%	65.36%	-2.69	★★★★
21–24 Years	76.12%	71.43%	-4.69	★★★★
Total	71.23%	67.84%	-3.39	★★★★
Frequency of Ongoing Prenatal Care				
*<21 Percent of Expected Visits**	1.72%	0.78%	-0.94	★★★★★
≥81 Percent of Expected Visits	63.15%	82.55%	19.40	★★★★★
Prenatal and Postpartum Care				
Postpartum Care	77.37%	80.99%	3.62	★★★★★
Timeliness of Prenatal Care	91.00%	93.23%	2.23	★★★★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Care for Chronic Conditions Performance Measure Results

KFHP QI's Care for Chronic Conditions performance measure results are shown in Table 3-33. While only one of the measure rates in this domain reported a significant improvement of more than 5 percentage points (i.e., *Medication Management for People With Asthma—Medication Compliance 50%—Total*), all but two rates were at or above the national Medicaid 50th percentile. Specifically, eight measure rates were at or above the 90th percentile, three measure rates were at or above the 75th percentile and below the 90th percentile, and one measure rate was at or above the 50th percentile and below the 75th percentile. Only the *Medication Management for People With Asthma* measure rates were below the 25th percentile. There were eight measures[3-14] in this domain with MQD Quality Strategy targets for HEDIS 2017, and all except the *Medication Management for People with Asthma* measure exceeded the established Quality Strategy targets.

[3-14] Within this domain, there are eight MQD Quality Strategy targets: *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg); Controlling High Blood Pressure*, and *Medication Management for People with Asthma* (two rates).

Table 3-33—KFHP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	91.58%	93.67%	2.09	★★★★★
Annual Monitoring for Members on Digoxin	—	96.67%	—	★★★★★
Annual Monitoring for Members on Diuretics	88.79%	93.41%	4.62	★★★★★
Total	90.63%	93.64%	3.01	★★★★★
Comprehensive Diabetes Care				
Blood Pressure Control (<140/90 mm Hg)	87.04%	81.30%	-5.74	★★★★★
Eye Exam (Retinal) Performed	71.35%	68.08%	-3.27	★★★★
HbA1c Control (<7.0%)	32.98%	33.90%	0.92	★★★
HbA1c Control (<8.0%)	58.04%	58.37%	0.33	★★★★
*HbA1c Poor Control (>9.0%)**	30.14%	30.13%	-0.01	★★★★
HbA1c Testing	95.93%	95.48%	-0.45	★★★★★
Medical Attention for Nephropathy	95.83%	95.08%	-0.75	★★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	83.21%	77.92%	-5.29	★★★★★
Medication Management for People With Asthma				
Medication Compliance 50%—Total	35.75%	42.02%	6.27	★
Medication Compliance 75%—Total	15.46%	18.59%	3.13	★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Behavioral Health Performance Measure Results

KFHP QI's Behavioral Health performance measure results are shown in Table 3-34. Of the five measure rates reported previously in 2016, none exhibited a significant improvement of more than 5 percentage points. Three of the measure rates were at or above the national Medicaid 50th percentile, with one of these measure rates at or above 90th percentile. Of the remaining three measure rates, all were below the 25th percentile. There is one measure in this domain with an MQD Quality Strategy target for HEDIS 2017 (i.e., *Follow-Up After Hospitalization for Mental Illness)*, and KFHP QI did not reach the established target, the 75th percentile.

Table 3-34—KFHP QI's HEDIS Results for QI Measures Under Behavioral Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	53.51%	44.75%	-8.76	★
Effective Continuation Phase Treatment	38.16%	28.79%	-9.37	★
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	—	NA	—	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	73.33%	—	★
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
30 Days—13–17 Years	—	NA	—	—
30 Days—18+ Years	—	33.33%	—	—
30 Days—Total	—	32.05%	—	—
7 Days—13–17 Years	—	NA	—	—
7 Days—18+ Years	—	23.61%	—	—
7 Days—Total	—	23.08%	—	—
Follow-Up After Emergency Department Visit for Mental Illness				
30-Day Follow-Up	—	73.05%	—	—
7-Day Follow-Up	—	46.81%	—	—

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	72.73%	70.09%	-2.64	★★★
7-Day Follow-Up	58.44%	53.27%	-5.17	★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	77.65%	72.86%	-4.79	★★★★★
Continuation and Maintenance Phase	—	NA	—	NA
Follow-up With Assigned PCP Following Hospitalization for Mental Illness*				
*Follow-up With Assigned PCP Following Hospitalization for Mental Illness***	—	8.33%	—	—

*** Non-HEDIS state-defined measure; rates were reported using an MS Excel reporting template.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.
A "NA" value indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30 cases) to report a valid rate, resulting a small denominator (NA) audit designation. It is also used to indicate when star ratings are not applicable.
A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:
1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Utilization and Health Plan Descriptive Information Performance Measure Results

KFHP's Utilization and Health Plan Descriptive Information performance measure results are shown in Table 3-35. Since utilization of more or fewer services is not indicative of performance, it is inappropriate to compare these rates to national Medicaid benchmarks. Of the measure rates reported previously in 2016, few measures exhibited a significant change in performance in 2017. However, the *Ambulatory Care—ED Visits per 1,000 Member Months* measure did meet and exceed the MQD Quality Strategy target—i.e., 90th percentile.

Table 3-35—KFHP's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	27.97	29.22	1.25	★★★★★
Outpatient Visits—Total	311.29	277.58	-33.71	—
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	—	57.13%	—	—
20–44 Years Subtotal Percentage—Total	—	25.89%	—	—
45–64 Years Subtotal Percentage—Total	—	15.31%	—	—
65+ Years Subtotal Percentage—Total	—	1.67%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
Maternity—Average Length of Stay—Total	2.42	2.84	0.42	—
Maternity—Days per 1,000 Member Months—Total	6.69	6.95	0.26	—
Maternity—Discharges per 1,000 Member Months—Total	2.76	2.44	-0.32	—
Medicine—Average Length of Stay—Total	4.96	5.19	0.23	—
Medicine—Days per 1,000 Member Months—Total	10.36	10.09	-0.27	—
Medicine—Discharges per 1,000 Member Months—Total	2.09	1.94	-0.15	—
Surgery—Average Length of Stay—Total	6.86	6.87	0.01	—
Surgery—Days per 1,000 Member Months—Total	5.26	5.03	-0.23	—
Surgery—Discharges per 1,000 Member Months—Total	0.77	0.73	-0.04	—
Total Inpatient—Average Length of Stay—Total	4.29	4.59	0.30	—

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Total Inpatient—Days per 1,000 Member Months—Total	19.98	19.75	-0.23	—
Total Inpatient—Discharges per 1,000 Member Months—Total	4.65	4.30	-0.35	—
Mental Health Utilization				
Any Service—Total	7.08%	7.55%	0.47	—
Inpatient—Total	0.32%	0.36%	0.04	—
Intensive Outpatient or Partial Hospitalization—Total	0.03%	0.14%	0.11	—
Outpatient, ED, or Telehealth—Total	7.01%	7.50%	0.49	—
Plan All-Cause Readmissions				
*Plan All-Cause Readmissions****	13.07%	10.49%	-2.58%	★★★★

** For this indicator, a lower rate indicates better performance.*
***** Measure was not available for Medicaid IDSS reporting; rates were reported using an MS Excel reporting template. The Medicare benchmark was used for the comparison to national percentile scoring.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.
A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:
1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Conclusions and Recommendations

Based on HSAG's analyses of those KFHP QI's measure rates with comparable benchmarks, 67 percent of KFHP QI's measure rates (38 of 57 rates) in 2017 ranked at or above the national Medicaid 75th percentile, with 25 measure rates scoring at or above the national Medicaid 90th percentile, indicating strong performance across all HEDIS domains. Moreover, KFHP QI met or exceeded the MQD Quality Strategy target for nearly all measures in 2017: *Childhood Immunization Status—Combination 3; Breast Cancer Screening; Cervical Cancer Screening*; *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits; Prenatal and Postpartum Care—Timeliness of Prenatal Care; Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg, Eye Exam (Retinal) Performed, HbA1c Control*

(<8.0%), HbA1c Poor Control (<9.0%), and *Hb1Ac Testing; Controlling High Blood Pressure;* and *Ambulatory Care—ED Visits per 1,000 Member Months*.

Conversely, only a small proportion of KFHP QI's rates (five of 57 rates) ranked below the national Medicaid 25th percentile in 2017, suggesting some opportunities for improvement across two domains of care—i.e., Care for Chronic Conditions and Behavioral Health. HSAG recommends that KFHP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Care for Chronic Conditions
  - *Medication Management for People With Asthma* (two rates)
- Behavioral Health
  - *Antidepressant Medication Management* (two rates)
  - *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Validation of Performance Improvement Projects

For validation year 2017, KFHP QI submitted two State-mandated PIP topics for validation: *All-Cause Readmissions* and *Diabetes Care*. The *All-Cause Readmissions* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality, timeliness of, and access to care and services. The focus of the PIP was to decrease the rate of members readmitted to the hospital within 30 days of a hospital discharge from Kaiser Foundation Hospital–Moanalua. The *Diabetes Care* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality of and access to care and services. The focus of the PIP was to increase the percentage of diabetic members with an HbA1c control value of less than 8 who have Provider A, B, or C as their primary care provider (PCP)at Nanaikeola clinic. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Findings

HSAG organized and analyzed KFHP QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal.

For each PIP, KFHP QI was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. KFHP QI developed a SMART Aim statement that quantified the improvement sought for each PIP. HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence, Confidence,* and *Low Confidence*. Table 3-36 outlines the PIP topics, final reported SMART Aim statements, and the overall validation findings for the two PIPs.

Table 3-36—PIP Topic, SMART Aim Statements, and Confidence Levels for KFHP QI

PIP Topic	SMART Aim Statement	Confidence Level
All-Cause Readmissions	By December 31, 2016, reduce the 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% to 12.7%.	*Confidence*
Diabetes Care	By December 31, 2016, increase the percentage of QUEST Integration members with a hemoglobin A1c < 8 from 51% to 60% at Nanaikeola Clinic who have Provider A, B, and C as their PCP.	*Low Confidence*

HSAG assigned the level of *Confidence* to KFHP QI's *All-Cause Readmissions* because they achieved meaningful and sustained improvement for the SMART Aim measure, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated. HSAG assigned the level of *Low Confidence* to KFHP QI's *Diabetes Care* PIPs since the quality improvement processes and interventions were poorly executed and could not be linked to the improvement; even though the SMART Aim goal was achieved.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

All-Cause Readmissions PIP

KFHP QI's focus for this PIP was to identify and test interventions to decrease the rate of members readmitted to the hospital within 30 days of a hospital discharge from KFHP QI Foundation Hospital—Moanalua. The health plan achieved the SMART Aim goal of decreasing readmissions from 13.2 percent to 12.7 percent by December 31, 2016. HSAG assigned a level of *Confidence* to this PIP. The details of the PIP's performance leading to the assigned confidence level are described below.

The health plan's rationale for selecting KFHP Foundation Hospital—Moanalua as the targeted facility for the PIP, and the PIP's initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. KFHP QI implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *All-Cause Readmissions* PIP are presented in Table 3-37 and in the narrative.

Table 3-37—KFHP QI's Intervention Testing for *All-Cause Readmiss*ions PIP

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Notification of service coordinator of member hospitalized and/or assign service coordinator	• Care coordination between inpatient and outpatient. • Patient barriers.	• Patient does not answer the telephone or return calls. • Patient does not understand discharge medication instructions.	The health plan chose to **adopt** this intervention.
Medication reconciliation during post-discharge telephone call.	• Medications. • Discharge instructions.	Patient does not understand discharge medication instructions.	The health plan chose to **adopt** this intervention.

HSAG validated KFHP QI's *All-Cause Readmissions* PIP SMART Aim measure rates based on the SMART Aim run chart in Module 5. Table 3-38 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 3-38—KFHP QI's SMART Aim Measure Results for All-Cause Readmissions PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
Readmission rate of QUEST Integration members hospitalized at Kaiser Foundation Hospital—Moanalua	13.2%	12.7%	0%	*Confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART aim goal rates as 13.2 percent and 12.7 percent, respectively. After the first intervention was implemented, the SMART Aim goal was reached in January 2016, with the lowest rate of zero readmissions reported in May and November 2016. The readmission rate remained at or below the SMART Aim goal for nine consecutive data points at the end of the measurement period. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *All-Cause Readmissions* PIP a level of *Confidence* because even though the SMART Aim goal was achieved and sustained, only one of the two interventions could be clearly linked to the demonstrated improvement.

Diabetes Care PIP

The focus of KFHP QI's *Diabetes Care* PIP was to identify and test interventions to increase the percentage of diabetic members with an HbA1c control value less than 8 at the narrowed focus provider. Although the health plan met the SMART Aim goal for the PIP, this success was not attributed to the

tested interventions because of low member participation in both interventions. HSAG assigned a level of *Low Confidence* to the PIP. The details of the PIP's performance leading to the assigned confidence level are described below.

The health plan's rationale for selecting three providers at the Nanaikeola Clinic as the targeted focus for the PIP, and the PIP's initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. KFHP QI implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *Diabetes Care* PIP are presented in Table 3-39.

Table 3-39—KFHP QI's Intervention Testing for *Diabetes Care* PIP

Intervention	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Dispense a 90-day supply of oral diabetic medications or diabetic testing supplies via mail order.	• Medication • Continuity of care • Access	Members are not refilling diabetes medications.	The health plan chose to **abandon** this intervention.
Assess barriers to medication compliance.	• Medication • Continuity of care	Members are not refilling diabetes medications.	The health plan chose to **abandon** this intervention.

HSAG validated KFHP QI's *Diabetes Care* PIP performance based on the rates that the health plan plotted on the SMART Aim run chart in Module 5. Table 3-40 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 3-40—KFHP QI's SMART Aim Measure Results for Diabetes Care PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Percentage of QI diabetic members with HbA1c < 8 at Nanaikeola Clinic who have Provider A, B and C as their PCP.	51%	60%	68%	*Low Confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART Aim goal rates as 51 percent and 60 percent, respectively. After the first intervention was implemented, the SMART Aim goal was achieved in December 2015, and thereafter all the remaining data points were maintained above the SMART Aim goal. The highest rate, 68 percent, was achieved in March 2016. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *Diabetes Care* PIP a level of *Low Confidence*. Even though the SMART Aim goal was achieved and

sustained, none of the implemented interventions could be clearly linked to the demonstrated improvement.

Strengths and Weaknesses

The validation findings suggest that KFHP QI was successful in executing the rapid-cycle *All-Cause Readmissions* PIP. The PIP was methodologically sound, achieved meaningful and sustained improvement for the SMART Aim measure, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement. Medication reconciliation intervention could not be executed properly due to staffing issues and hence could not be linked to improvement. Therefore, HSAG assigned a level of *Confidence* to the PIP.

For the *Diabetes Care* PIP, HSAG assigned the health plan a level of *Low Confidence.* The health plan achieved the SMART Aim goal for this PIP, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement. Due to low member participation, neither intervention could be linked to the demonstrated improvement.

Recommendations for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the improvement strategies used must be methodologically sound and based on solid improvement science. KFHP QI's PIP performance suggested several areas of opportunity that applied across the various PIP topics. HSAG recommended the following for KFHP QI:

- Ensure that the interventions are started in a timely manner. If delays occur, the health plan may not have incurred enough data points by the SMART Aim end date.
- Provide weekly or monthly data points showing the data and progress of intervention evaluation over time.
- Ensure that the core PIP team includes analytical staff members who are involved in all data-related processes of the PIP.
- Consider testing interventions in multiple environments before adoption.

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

The following is a summary of the Child CAHPS performance highlights for KFHP QI. The performance highlights are broken into two key areas:

- Statewide Comparisons
- NCQA Comparisons

Findings

Table 3-41 presents KFHP QI's results from these analyses. For the four global ratings, five composite measures, and two individual item measures, the table depicts KFHP QI's trended summary rates[3-15] and statistical testing results (i.e., ▲ or ▼), and the 2016 NCQA National Average.[3-16] Additionally, KFHP QI's overall member satisfaction ratings (i.e., star ratings) are displayed below. Caution should be used when evaluating results with less than 100 respondents (i.e., +).

Table 3-41—Child Medicaid CAHPS Results *for* KFHP QI

Measure	2015 Rates	2017 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	75.9%	73.9%	★★★★★
Rating of All Health Care	72.0%	70.0%	★★★★★
Rating of Personal Doctor	83.1%	80.0%	★★★★★
Rating of Specialist Seen Most Often	77.6%+	72.0%+	★★★★
Composite Measures			
Getting Needed Care	82.4%	84.2%	★★
Getting Care Quickly	90.2%	90.5%	★★
How Well Doctors Communicate	96.5%	96.8%	★★★★★
Customer Service	88.8%	92.5%	★★★★
Shared Decision Making	86.8%	81.4%	—
Individual Item Measures			
Coordination of Care	89.8%	89.9%	★★★★
Health Promotion and Education	80.0%	76.1%	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.

Statistical Significance Note: ▲ indicates the 2017 score is statistically significantly higher than the 2015 score

▼ indicates the 2017 score is statistically significantly lower than the 2015 score

(+) indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.

Star Ratings based on percentiles:

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

[3-15] The child population was last surveyed in 2015; therefore, the 2017 CAHPS scores are compared to the corresponding 2015 scores.

[3-16] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

The trend analysis of KFHP QI's summary measure rates revealed the following:

- KFHP QI did not score statistically significantly higher or lower in 2017 than in 2015 on any measure.
- KFHP QI scored at or above the national average on all 11 measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education.*

The detailed results of the comparison to NCQA benchmarks highlighted the following:

- KFHP 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 *How Well Doctors Communicate.*
- KFHP QI scored at or between the 75th and 89th percentiles on three measures: *Rating of Specialist Seen Most Often, Customer Service,* and *Care Coordination.*
- KFHP QI scored at or between the 50th and 74th percentiles on none of the measures.
- KFHP QI scored at or between the 25th and 49th percentiles on two measures: *Getting Needed Care* and *Getting Care Quickly.*
- KFHP QI did not score below the 25th percentile on any measure.

In addition, an evaluation of performance of three beneficiary satisfaction Quality Strategy measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—compared to NCQA's 2017 Benchmarks and Thresholds for Accreditation[3-17] was performed for KFHP QI. Two of the beneficiary satisfaction Quality Strategy measures for KFHP QI met or exceeded the 75th percentile goal.

Strengths

For KFHP QI's child Medicaid population, seven of the measures met or exceeded the 75th percentile (i.e., *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, How Well Doctors Communicate, Rating of Specialist Seen Most Often, Customer Service*, and *Coordination of Care),* and all 11 measures met or exceeded the 2016 NCQA child Medicaid national average: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.

[3-17] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

Areas for Improvement

Based on a comprehensive assessment of KFHP QI's CAHPS results, three potential areas for improvement were identified: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. HSAG evaluated each of these areas to determine if certain CAHPS items (i.e., questions) are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers" are driving levels of satisfaction with each of the three measures. Given that these measures are driving members' level of satisfaction with each of the priority areas, KFHP QI should consider determining whether potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-42 depicts the individual key drivers KFHP QI should consider focusing on for each of the potential priority areas for quality improvement.

Table 3-42—KFHP QI Key Drivers of Satisfaction

Getting Needed Care
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Getting Care Quickly
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Customer Service
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about KFHP QI's performance in providing quality, accessible, and timely healthcare and services to its members.

Conclusions

In general, KFHP QI's performance results illustrate strong performance across the four EQR activities. HSAG's compliance monitoring review activity suggests that KFHP QI has a solid operational foundation to support the quality, access, and timeliness of care and service delivery. Moreover, health plan performance on 2017 HEDIS measures and the CAHPS survey indicate a high level of performance across all measurement domains.

KFHP QI's compliance review revealed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. However, deficiencies were noted within two key review areas (i.e., Subcontracts and

Delegation and Credentialing), and were targeted for CAPs. As such, the health plan demonstrated moderate compliance (i.e., 88 percent) with federal and State contract requirements for structure and operations. KFHP QI continued to demonstrate its commitment to quality process improvement by closing all its CAPs from the previous year's compliance review.

Overall, approximately two-thirds (67 percent) of KFHP QI's measure rates fell at or above the NCQA national Medicaid 75th percentile across all measurement domains, with 26 measures scoring at or above the 90th percentile. Conversely, only 9 percent of the measure rates fell below the 25th percentile. KFHP QI performance did identify a few areas needing improvement including *Care for Chronic Conditions* and *Behavioral Health* domains. Twelve of KFHP QI's measure rates met the MQD's Quality Strategy targets for beneficiary satisfaction.

Similarly, KFHP QI's CAHPS results suggest strong member satisfaction, with seven measure results being at or above the 75th percentile. Moreover, KFHP QI scored at or above the national average on nine measures: *Rating of Health Plan*, *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making, Coordination of Care*, and *Health Promotion and Education.* KFHP QI met or exceeded two of the three MQD Quality Strategy targets.

The results of KFHP QI's PIPs indicate a need for ongoing quality improvement training of staff. HSAG assessed KFHP QI's *All-Cause Readmissions* PIP with *Confidence* but assessed its *Diabetes Care* PIP with *Low Confidence.* While the validation findings determined that KFHP QI met the SMART Aim goals for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. These results suggest that KFHP continues to have opportunities for improvement in executing the rapid-cycle PIP process. HSAG recommends ongoing QI training specific to the rapid-cycle PIP process to improve results of State-mandated PIPs.

‘Ohana Health Plan QUEST Integration (‘Ohana QI) Results

Compliance Monitoring Review

Table 3-43 presents the standards and compliance scores for ‘Ohana QI. For standards I–VI, HSAG evaluated a total of 75 elements for the CY 2017 review period. Each element was scored as *Met*, *Partially Met*, *Not Met,* or *Not Applicable* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

Table 3-43—Standards and Compliance Scores—’Ohana QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	9	0	0	0	100%
III	Credentialing	45	41	35	6	0	4	93%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**75**	**69**	**6**	**0**	**4**	**96%**

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

***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *NA*.

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

Findings

‘Ohana QI had a total compliance score of 96 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.

Strengths

Below is a discussion of the strengths, by standard, that were identified during the compliance review.

Provider Selection: ‘Ohana QI was found to be compliant with 100 percent of the *Provider Selection* standard. The health plan demonstrated that it effectively used its provider manual, and periodically, the quarterly provider newsletters to regularly communicate to providers. ‘Ohana QI’s policies and procedures for developing and maintaining its provider network included all required provisions, as did

the provider agreement templates. Initial provider orientation included an array of information about the health plan including health plan operations, organizational structure, benefit packages, coding procedures to ensure accurate HEDIS data, billing procedures, disease management and other member programs, the Community Care Services (CCS) program and its relationship to the ‘Ohana QI health plan, member rights, grievance and appeal processes, communication tips, and how to participate in the UM and QM programs. During the on-site interviews, ‘Ohana QI staff members described use of a dashboard that displayed providers’ performance to assist provider service representatives in determining the schedule and frequency of one-to-one educational sessions based on individual provider needs.

‘Ohana QI’s compliance plan—a WellCare corporate document—was comprehensive and addressed each of the required provisions. Policies and procedures provided Hawaii-specific processes related to compliance training; communication; and reporting of compliance issues and FWA.

Subcontracts and Delegation: ‘Ohana QI was found to be compliant with 100 percent of the *Subcontracts and Delegation* standard. ‘Ohana QI had clear processes for oversight and monitoring of subcontracted delegates. The health plan’s policies and procedures, contract templates, DOC meeting minutes, as well as examples of completed audits demonstrated ‘Ohana QI’s processes designed to maintain responsibility for all delegated tasks. ‘Ohana QI conducted a pre-delegation audit, had effective processes for conducting annual audits, and followed CAPs through to completion of all corrective actions.

‘Ohana QI had several delegation agreement templates based on the type of administrative activity being delegated. Policies and procedures and all delegation contract templates included the required provisions. In addition to annual auditing (formal review), ‘Ohana QI required regular status reports based on the activity delegated, as well as self-reported compliance with requirements of the contract using electronic scorecards via the Compliance 360 software program.

HSAG found ‘Ohana QI’s practices regarding what the health plan considered to be a delegated activity (e.g., when a facility such as a hospital or clinic credentials its own practitioners) to be effective and in compliance; however, ‘Ohana QI may want to consider consulting the *NCQA Standards and Guidelines for Health Plan Accreditation* publication to determine if following the credentialing standards for assessment of organizational providers may be more applicable, cost-effective, and less burdensome for ‘Ohana QI.

Credentialing: ‘Ohana QI was found to be compliant with 93 percent of the *Credentialing* standard, with six elements scoring *Partially Met*. ‘Ohana QI had effective operational processes for credentialing and recredentialing independent practitioners, and its credentialing and recredentialing policies and procedures were NCQA compliant and included all of the required provisions. Further, on-site review of credentialing and recredentialing records revealed timely primary source verification of credentials, recredentialing, and exclusion searches using the NCQA-approved databases, as well as completed ownership and disclosure documents from providers and practitioners.

Provider agreement templates and practitioner credentialing and recredentialing applications contained all the required information, the credentialing delegation subcontracts included all of the required

provisions, and ‘Ohana QI provided evidence of pre-delegation audits, ongoing monitoring and oversight, as well as annual audits (formal review).

Quality Assessment and Performance Improvement: ‘Ohana QI was found to be compliant with 100 percent of the *Quality Assessment and Performance Improvement* standard. Local, Hawaii-based staff members participated in ‘Ohana QI’s QAPI program and activities, with additional support, leadership, and consultation from its corporate headquarters in Tampa. The ‘Ohana QI QAPI program was supported by numerous policies, procedures, and plans guiding expectations for the care and service delivery system, which also provided the framework through which monitoring and improvement activities were conducted.

The health plan’s comprehensive quality improvement program description included its QAPI organizational structure, roles and responsibilities, governance, and committee and subcommittee structure. The scope of the QAPI program activities included all member demographic groups, care settings, and types of services, and the planned improvement activities were documented in an annual workplan with goals, metrics, identification of responsible individuals and committees, and time frames for reporting.

The health plan also provided its UM program description and relevant policies and procedures, which were evidence of ‘Ohana QI’s ongoing monitoring of its service utilization patterns and detection of over- and underutilization. Committee minutes and on-site interview discussions provided further evidence that the health plan used these findings in its overall QAPI program. In addition, ‘Ohana QI staff discussed its performance improvement initiatives aiming at reducing hospital readmissions and described the specific activities and measurements that were in place to monitor the impact of its quality interventions. The ‘Ohana QI QAPI program was supported by numerous policies, procedures, and plans guiding expectations for the care and service delivery system, which also provided the framework through which monitoring and improvement activities were conducted.

Health Information Systems: ‘Ohana QI was found to be compliant with 100 percent of the *Health Information Systems* standard. While the WellCare corporate office in Tampa maintained the core processing systems, network, and databases used by the health plan, ‘Ohana QI had access to Hawaii-based IS staff and data analysts to fulfill its business, regulatory, and ad hoc reporting needs and requirements, and to assist with trending data for its quality and utilization management programs.

‘Ohana QI’s information system flow diagrams, policy and process documents, various reports, and staff members’ on-site interview responses provided evidence of the health plan’s ability to collect and report information on grievances and appeals, member and provider characteristics, services, utilization management data, and quality reporting metrics, among other data. Processes were in place to ensure data security and health information privacy.

‘Ohana QI had corporate-level policies and plans related to disaster planning, disaster recovery, and business continuity which centered on data backup and redundancy in support of each local market. The health plan also provided a Hawaii-specific business impact analysis document and a business continuity plan that demonstrated its local plan for readiness and assignment of responsibilities to maintain continuity during a loss, disruption, or interruption of critical business processes.

Practice Guidelines: 'Ohana QI was found to be compliant with 100 percent of the *Practice Guidelines* standard. 'Ohana QI's process for practice guideline adoption was initiated through the WellCare corporate Medical Policy Committee, with a membership consisting of many WellCare medical directors from all markets and representing all specialties. The selected CPGs were then reviewed by the Hawaii Utilization Management Committee (UMAC), and finally approved through the Quality Improvement Committee (QIC).

'Ohana QI had numerous CPGs for medical conditions and for preventive care, including Asthma, Diabetes, and Pediatric Preventive Health CPGs. Links to the CPGs were available to providers on the 'Ohana QI website through the provider portal, and reminders about the location of the online CPGs and other provider resources were published in provider newsletters regularly. Additional comprehensive practice guideline information was contained in various provider "tool kits" that were given as resources to providers, and that provided technical assistance with coding of services and medical record documentation for certain conditions, as well as education about the HEDIS measure requirements for the conditions, if applicable. To monitor whether actual practice was consistent with the CPGs, quality of care cases was reviewed against the desired practice in the applicable guideline.

Areas for Improvement

Below is a discussion of the areas for improvement, by standard, that were identified during the compliance review, and subject to implementation of a CAP.

Credentialing: 'Ohana QI's Credentialing and Recredentialing procedure stated that notification of practitioner rights is included in the application/re-application cover letter and in the provider manual. However, during the on-site record review, there were no application cover letters within the credentialing/recredentialing records. Staff members stated that cover letters were not used. For initial credentialing applicants who do not yet have access to the provider manual, this method is not sufficient for notification of applicants' rights under 'Ohana QI's credentialing program. ***'Ohana QI must develop a mechanism to notify initial credentialing applicants about their rights to review information submitted to support their credentialing application, to correct erroneous information, and to receive the status of their credentialing or recredentialing application.***

The on-site organizational provider initial credentialing and recredentialing record reviews revealed that three home healthcare agency files did not contain evidence of licensure (required in the State of Hawaii). ***'Ohana QI must ensure that the health plan confirms that organizational providers are in good standing with State regulatory bodies (e.g., State licensing agencies).*** This must occur before contracting with any organizational provider, and every three years thereafter.

The on-site organizational provider record review also revealed that 'Ohana QI did not perform an on-site quality assessment for the nonaccredited organizations in the sample reviewed. In one case, 'Ohana QI accepted a Medicare site visit in lieu of its own on-site quality assessment; however, the report obtained by 'Ohana QI included only deficiencies, and there was no evidence that 'Ohana QI had assessed the survey content to confirm that the assessment met the health plan's quality assessment standards as articulated in 'Ohana QI's policy. ***'Ohana QI must develop a mechanism to conduct on-***

site quality assessments for organizational providers that are not accredited. If the health plan chooses to accept a CMS or State survey in lieu of conducting an on-site quality assessment, 'Ohana QI must ensure that the survey meets the health plan's standards for an on-site quality assessment. This can be accomplished as described in 'Ohana QI's policy, or the health plan may establish a threshold for the survey that 'Ohana QI will accept for participation in the network (for example, a percentage score or maximum number of deficiencies allowed). If 'Ohana QI chooses a mechanism other than that described in the policy, the health plan's policy must be revised to reflect the process used.

On-site review of recredentialing files for organizational providers revealed that 'Ohana QI did not consistently obtain complete ownership and control documents at recredentialing. In some cases, the documents were missing from the file, and in other cases the documents were incomplete. ***'Ohana QI must comply with contract requirements and its own process designed to obtain completed ownership and control documents from all providers at the time of recredentialing.***

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated 'Ohana QI's IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) 'Ohana QI was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that 'Ohana QI had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. 'Ohana QI elected to use three standard and 11 nonstandard supplemental data sources for its performance measure reporting. During the validation process of these supplemental data sources, errors were discovered within one of the nonstandard data sources. 'Ohana QI removed the errors, and the data sources were approved for HEDIS 2016 measure reporting. All convenience samples passed HSAG's review.

Based on 'Ohana QI's data systems and processes, the auditors made two recommendations:

- While errors identified during primary source verification of the non-standard data sources were resolved during validation, it was identified that there was concern with how data were captured in the database as compared to the source. HSAG recommended 'Ohana QI increase oversight of its non-standard supplemental data process and ensure that it follows the *HEDIS 2017, Volume 2: Technical Specifications for Health Plans*.
- HSAG recommended that only data sources relevant to the measures as part of the audit scope be included in the Record of Administration, Data Management and Processes (Roadmap).

All QI measures which 'Ohana QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted for the measure. Five measures received an *NA* designation due to small denominators—i.e., *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (7-Day and 30-Day for 13–17 years), Initiation and Engagement of Alcohol and Other Drug*

Dependence Treatment, Medication Management for People With Asthma, and *Follow-Up Care for Children Prescribed ADHD Medication*. 'Ohana QI experienced no enrollment complications related to properly identifying these members on the daily and monthly enrollment files. Eligibility was properly identified within its enrollment system. 'Ohana QI passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Controlling High Blood Pressure*
- Group B: Anticipatory Guidance & Counseling—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition*
- Group C: Laboratory—*Comprehensive Diabetes Care— HbA1c Control (<8.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 3*
- Group F: Exclusions—*All Medical Record Exclusions*

Access to Care Performance Measure Results

'Ohana QI's Access to Care performance measure results are shown in Table 3-44. None of the rates in this domain reported a significant improvement of more than 5 percentage points. Two measure rates were at or above the national Medicaid 50th percentile but below the 75th percentile; one measure rate was between the 25th percentile and 50th percentile; and the remaining seven measures were below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2017.

Table 3-44—'Ohana QI's HEDIS Results for QI Measures Under Access to Care

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	64.70%	60.74%	-3.96	★
45–64 Years	82.44%	80.42%	-2.02	★
65 Years and Older	90.61%	90.40%	-0.21	★★★
Total	77.49%	74.57%	-2.92	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	85.25%	89.95%	4.70	★
25 Months–6 Years	76.49%	72.32%	-4.17	★
7–11 Years	83.91%	80.26%	-3.65	★
12–19 Years	83.14%	79.79%	-3.35	★

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	36.00%	35.88%	-0.12	★★
Engagement of AOD Treatment	9.21%	10.79%	1.58	★★★

2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Children's Preventive Health Performance Measure Results

'Ohana QI's Children's Preventive Health performance measure results are shown in Table 3-45. All three of the measure rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure reported a significant improvement of more than 5 percentage points in 2017. However, only one measure rate was at or above the national Medicaid 75th percentile but below the 90th percentile. The remaining measures were below the 25th percentile except for two of the indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure. There was one measure in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Childhood Immunization Status—Combination 3*), and 'Ohana QI did not reach the established target, the 75th percentile.

Table 3-45—'Ohana QI's HEDIS Results for QI Measures Under Children's Preventive Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	31.18%	29.68%	-1.50	★
Childhood Immunization Status				
Combination 3	52.05%	46.95%	-5.10	★
Hepatitis B	69.59%	62.33%	-7.26	★
HiB	70.18%	66.31%	-3.87	★
IPV	66.08%	63.93%	-2.15	★
MMR	70.47%	68.70%	-1.77	★
Pneumococcal Conjugate	56.14%	50.13%	-6.01	★
VZV	69.88%	67.64%	-2.24	★

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Immunizations for Adolescents				
Combination 1	43.58%	40.97%	-2.61	★
Combination 2	—	11.45%	—	—
HPV	—	13.22%	—	—
Meningococcal	45.87%	45.81%	-0.06	★
Tdap	48.17%	45.37%	-2.80	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	5.96%	3.87%	-2.09	★
Six or More Well-Child Visits	53.66%	53.04%	-0.62	★
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	57.64%	57.57%	-0.07	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	72.45%	85.40%	12.95	★★★★
Counseling for Nutrition—Total	52.31%	61.80%	9.49	★★
Counseling for Physical Activity—Total	45.83%	52.55%	6.72	★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Women's Health Performance Measure Results

'Ohana QI's Women's Health performance measure results are shown in Table 3-46. Only one of the rates in this domain reported a significant improvement of more than 5 percentage points (i.e., *Timeliness of Prenatal Care)*. Six measure rates were at or above the national Medicaid 25th percentile but below the 50th percentile, and the remaining three measures were below the 25th percentile. There were four measures in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Breast Cancer Screening, Cervical Cancer Screening, Frequency of Ongoing Prenatal Care,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*); however, none of the 'Ohana QI's measure rates met or exceeded the established Quality Strategy targets.

Table 3-46—'Ohana QI's HEDIS Results for QI Measures Under Women's Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	55.62%	52.71%	-2.91	★★
Cervical Cancer Screening				
Cervical Cancer Screening	45.56%	44.04%	-1.52	★
Chlamydia Screening in Women				
16–20 Years	43.26%	46.97%	3.71	★★
21–24 Years	53.58%	56.15%	2.57	★★
Total	50.15%	53.06%	2.91	★★
Frequency of Ongoing Prenatal Care				
*<21 Percent of Expected Visits**	12.53%	14.60%	2.07	★★
≥81 Percent of Expected Visits	44.82%	44.04%	-0.78	★
Prenatal and Postpartum Care				
Postpartum Care	50.60%	46.47%	-4.13	★
Timeliness of Prenatal Care	69.16%	76.40%	7.24	★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Care for Chronic Conditions Performance Measure Results

'Ohana QI's Care for Chronic Conditions performance measure results are shown in Table 3-47. Although none of the measure rates in this domain reported a significant improvement of more than 5 percentage points, eight of the measure rates were at or above the national Medicaid 50th percentile; five of these measure rates were at or above the 75th percentile but below 90th percentile. Three measure rates were at or above the 50th percentile, and only one measure rate (i.e., *Annual Monitoring for Members on Digoxin*) was below the national Medicaid 25th percentile. There were eight measures[3-18] in this domain with MQD Quality Strategy targets for HEDIS 2017; however, only two of 'Ohana QI's measure rates met or exceeded the established Quality Strategy targets (i.e., *Medication Management for People With Asthma—50%* and *75% Compliant)*.

Table 3-47—'Ohana QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	91.62%	91.61%	-0.01	★★★★
Annual Monitoring for Members on Digoxin	49.52%	46.07%	-3.45	★
Annual Monitoring for Members on Diuretics	92.83%	91.86%	-0.97	★★★★
Total	91.25%	90.97%	-0.28	★★★★
Comprehensive Diabetes Care				
Blood Pressure Control (<140/90 mm Hg)	59.00%	60.61%	1.61	★★★
Eye Exam (Retinal) Performed	56.52%	60.39%	3.87	★★★
HbA1c Control (<7.0%)	31.66%	33.00%	1.34	★★
HbA1c Control (<8.0%)	47.53%	45.93%	-1.60	★★
*HbA1c Poor Control (>9.0%)**	42.86%	45.64%	2.78	★★
Hemoglobin A1c (HbA1c) Testing	84.00%	85.32%	1.32	★★
Medical Attention for Nephropathy	89.77%	89.53%	-0.24	★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	57.17%	55.58%	-1.59	★★★

[3-18] Within this domain, there are eight MQD Quality Strategy targets: *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed,* and *Blood Pressure Control (<140/90 mm Hg); Controlling High Blood Pressure*, and *Medication Management for People with Asthma* (two rates).

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Medication Management for People With Asthma				
Medication Compliance 50%—Total	67.41%	65.70%	-1.71	★★★★
Medication Compliance 75%—Total	48.66%	43.80%	-4.86	★★★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Behavioral Health Performance Measure Results

'Ohana QI's Behavioral Health performance measure results are shown in Table 3-48. Of the four measure rates reported previously in 2016, two measures exhibited a significant improvement of more than 5 percentage points; however, none of the measure rates were at or above the national Medicaid 50th percentile. Three measure rates were at or above the 25th percentile but below the 50th percentile, and two measures were below the 25th percentile. There is one measure in this domain with an MQD Quality Strategy target for HEDIS 2017 (i.e., *Follow-Up After Hospitalization for Mental Illness)*, and 'Ohana QI did not reach the established target, the 75th percentile.

Table 3-48—'Ohana QI's HEDIS Results for QI Measures Under Behavioral Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	52.63%	48.19%	-4.44	★
Effective Continuation Phase Treatment	38.48%	35.32%	-3.16	★★
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	—	NA	—	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	73.88%	—	★

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
30 Days—13–17 Years	—	NA	—	—
30 Days—18+ Years	—	14.86%	—	—
30 Days—Total	—	14.58%	—	—
7 Days—13–17 Years	—	NA	—	—
7 Days—18+ Years	—	8.25%	—	—
7 Days—Total	—	8.10%	—	—
Follow-Up After Emergency Department Visit for Mental Illness				
30-Day Follow-Up	—	43.22%	—	—
7-Day Follow-Up	—	25.71%	—	—
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	43.73%	61.17%	17.44	★★
7-Day Follow-Up	24.71%	37.80%	13.09	★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	NA	—	NA
Continuation and Maintenance Phase	—	NA	—	NA
Follow-up With Assigned PCP Following Hospitalization for Mental Illness**				
*Follow-up With Assigned PCP Following Hospitalization for Mental Illness***	—	28.10%	—	—

*** Non-HEDIS state-defined measure; rates were reported using an MS Excel reporting template.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "NA" value indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30 cases) to report a valid rate, resulting a small denominator (NA) audit designation. It is also used to indicate when star ratings are not applicable.

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Utilization and Health Plan Descriptive Information Performance Measure Results

'Ohana QI's Utilization and Health Plan Descriptive Information performance measure results are shown in Table 3-49. Utilization of more or fewer services is not indicative of performance; therefore, it is inappropriate to compare these rates to national Medicaid benchmarks. Of the measure rates reported previously in 2016, few measures exhibited a significant change in performance in 2017. There was one measure in this domain with an MQD Quality strategy target (i.e., *Ambulatory Care—ED Visits per 1,000 Member Months)*; 'Ohana QI did not meet and exceed threshold—i.e., 90th percentile.

Table 3-49—'Ohana QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	64.70	64.65	-0.05	★★
Outpatient Visits—Total	493.00	502.90	9.90	—
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	—	22.62%	—	—
20–44 Years Subtotal Percentage—Total	—	33.32%	—	—
45–64 Years Subtotal Percentage—Total	—	28.78%	—	—
65+ Years Subtotal Percentage—Total	—	15.28%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
Maternity—Average Length of Stay—Total	2.59	2.65	0.06	—
Maternity—Days per 1,000 Member Months—Total	5.84	5.59	-0.25	—
Maternity—Discharges per 1,000 Member Months—Total	2.25	2.11	-0.14	—
Medicine—Average Length of Stay—Total	5.11	5.59	0.48	—
Medicine—Days per 1,000 Member Months—Total	46.27	51.29	5.02	—
Medicine—Discharges per 1,000 Member Months—Total	9.05	9.17	0.12	—

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	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Surgery—Average Length of Stay—Total	12.02	12.06	0.04	—
Surgery—Days per 1,000 Member Months—Total	50.88	45.43	-5.45	—
Surgery—Discharges per 1,000 Member Months—Total	4.23	3.77	-0.46	—
Total Inpatient—Average Length of Stay—Total	6.81	6.97	0.16	—
Total Inpatient—Days per 1,000 Member Months—Total	101.28	100.73	-0.55	—
Total Inpatient—Discharges per 1,000 Member Months—Total	14.87	14.45	-0.42	—
Mental Health Utilization				
Any Service—Total	14.71%	14.28%	-0.43	—
Inpatient—Total	1.14%	1.03%	-0.11	—
Intensive Outpatient or Partial Hospitalization—Total	0.05%	0.08%	0.03	—
Outpatient, ED, or Telehealth—Total	14.16%	13.93%	-0.23	—
Plan All-Cause Readmissions				
*Plan All-Cause Readmissions****	18.08%	16.95%	-1.13%	★★

** For this indicator, a lower rate indicates better performance.*
**** Measure was not available for Medicaid IDSS reporting; rates were reported using an MS Excel reporting template. The Medicare benchmark was used for the comparison to national percentile scoring.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Conclusions and Recommendations

Based on HSAG's analyses of those 'Ohana QI's measure rates with comparable benchmarks, only 11 percent of 'Ohana QI's measure rates (six of 57 rates) were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile in 2017, indicating positive performance related to the weight assessment and counseling for nutrition and physical activity for children and adolescents, as well as the monitoring of patients on persistent medications and medication management for people with asthma. Moreover, 'Ohana QI met or exceeded the MQD Quality Strategy target for two measures in 2017: *Medication Management for People With Asthma—50% Compliance* and *75% Compliance*.

Conversely, most of the 'Ohana QI's rates that were comparable to national benchmarks ranked below the national Medicaid 25th percentile in 2017 (27 of 57 rates), suggesting considerable opportunities for improvement across all domains of care. HSAG recommends that 'Ohana QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services* (three rates)
  - *Children and Adolescents' Access to Primary Care Practitioners* (four rates)
- Children's Preventive Care
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status* (seven rates)
  - *Immunizations for Adolescents* (three rates)
  - *Well-Child Visits in the First 15 Months of Life* (two rates)
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care* (one rate)
  - *Frequency of Ongoing Prenatal Care* (one rate)
- Care for Chronic Conditions
  - *Annual Monitoring for Patients on Persistent Medications* (one rate)
- Behavioral Health
  - *Antidepressant Medication Management* (one rate)
  - *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Validation of Performance Improvement Projects

For validation year 2017, 'Ohana QI submitted two State-mandated PIP topics for validation: *All-Cause Readmissions* and *Diabetes Care*. The *All-Cause Readmissions* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality, timeliness of, and access to care and services. The focus of the PIP was to decrease the rate of 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. The *Diabetes Care* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality of and access to care and services. The focus of the PIP was to increase the percentage of diabetic members with Magdy Mettias, MD, or Laurie Lee, MD, as their primary care provider (PCP) and had an annual diabetic retinal exam. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Findings

HSAG organized and analyzed 'Ohana QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal.

For each PIP, 'Ohana QI was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. 'Ohana QI developed a SMART Aim statement that quantified the improvement sought for each PIP. HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence, Confidence,* and *Low Confidence*. Table 3-50 outlines the PIP topics, final reported SMART Aim statements, and the overall validation findings for the two PIPs.

Table 3-50—PIP Topic, SMART Aim Statements, and Confidence Levels for 'Ohana QI

PIP Topic	SMART Aim Statement	Confidence Level
All-Cause Readmissions	By December 31, 2016, the 30-day all-cause readmissions rate will reduce from 18.4% to 8.4% for members discharged from the hospital who had a primary admitting diagnosis of heart failure or diabetes.	*Low Confidence*
Diabetes Care	By December 31, 2016, increase the aggregate diabetic retinal exam rate from 36.9% to 54.0% for eligible diabetic members between the ages of 18–75 who are due for a diabetic retinal exam and who have Laurie Lee, MD, or Magdy Mettias, MD, as their PCP.	*Low Confidence*

HSAG assigned the level of *Low Confidence* to 'Ohana QI's *All-Cause Readmissions* and *Diabetes Care* PIPs. Although the SMART Aim goal was achieved for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

All-Cause Readmissions PIP

'Ohana QI's focus for this PIP was to identify and test interventions to decrease all-cause readmission rates for members discharged from the hospital who had a primary admitting diagnosis of heart failure or diabetes. The health plan achieved the SMART Aim goal of decreasing readmissions from 18.4 percent to 8.4 percent by December 31, 2016. HSAG assigned a level of *Low Confidence* to this PIP. The details of the PIP's performance leading to the assigned confidence level are described below.

The health plan's rationale for selecting heart failure and diabetes-related readmissions as its narrowed focus, and the PIP's initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. 'Ohana QI implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *All-Cause Readmissions* PIP are presented in Table 3-51.

Table 3-51—'Ohana QI's Intervention Testing for *All-Cause Readmis*sions PIP

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
After Hospitalization Outreach Program (AHOP)	• Identifying members discharged from the hospital who had a primary admitting diagnosis of heart failure or diabetes. • Contacting members. • Member awareness.	• No follow-up to the member was completed after a missed appointment to schedule a new appointment with his/her primary care physician (PCP). • The member forgot to schedule a follow-up appointment with his/her PCP post hospital discharge. • The member was not provided with information about the importance of following up with the PCP.	The health plan chose to **abandon** this intervention.

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Disease management educational mailers	• Contacting members. • Chronic disease management.	• The member forgot to schedule a follow-up appointment with his/her PCP post hospital discharge. • The member was not provided information about the importance of following up with the PCP.	The health plan chose to **abandon** this intervention.

HSAG validated ‘Ohana QI’**s** *All-Cause Readmissions* PIP SMART Aim measure rates based on the SMART Aim run chart in Module 5. Table 3-52 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 3-52—’Ohana QI’s SMART Aim Measure Results for All-Cause Readmissions PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
All-cause readmissions rate for members discharged from the hospital who had a primary admitting diagnosis of heart failure or diabetes	18.4%	8.4%	0%	*Low confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART aim goal rates as 18.4 percent and 8.4 percent, respectively. The SMART Aim goal was reached in September 2015, when the readmissions rate was zero. The readmissions rate remained at zero from December 2015 through December 2016, except for March and September when the rates exceeded the goal. After a comprehensive review and evaluation of the health plan’s PIP documentation, HSAG assigned the *All-Cause Readmissions* PIP *a* level of *Low Confidence*. Even though the SMART Aim goal was achieved, none of the implemented interventions could be clearly linked to the demonstrated improvement.

Diabetes Care PIP

The focus of ‘Ohana QI’s *Diabetes Care* PIP was to identify and test interventions to increase the aggregate diabetic retinal exam rate among eligible diabetic members who are due for a diabetic retinal exam at the narrowed focus provider. Although the health plan met the SMART Aim goal for the PIP, this success was not attributed to the tested interventions. HSAG assigned a level of *Low Confidence* to

the PIP. The details of the PIP's performance leading to the assigned confidence level are described below.

The health plan's rationale for selecting the two primary care providers as the targeted focus for the PIP, and the PIP's initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. 'Ohana QI implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *Diabetes Care* PIP are presented in Table 3-53.

Table 3-53—'Ohana QI's Intervention Testing for *Diabetes Care* PIP

Intervention	Key Drivers Addressed	Failure Modes Addressed	Conclusions
FirstVitals—mobile diabetic retinal exam	Provider availability	• The member is not interested in understanding the information provided. • The scheduling process is too difficult for the member. • The member forgets about the diabetic retinal exam appointment.	The health plan chose to **abandon** this intervention.
'Ohana Health Plan telephonic outreach program for retinal eye exam	Member outreach	Scheduling assistance is not provided by the PCP.	The health plan chose to **abandon** this intervention.

HSAG validated 'Ohana QI's *Diabetes Care* PIP performance based on rates that the health plan plotted on the SMART Aim run chart in Module 5. Table 3-54 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 3-54—'Ohana QI's SMART Aim Measure Results for Diabetes Care PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Diabetic retinal exam rate among eligible diabetic members between the ages of 18–75 years old who are due for a diabetic retinal exam and who have Laurie Lee, MD, or Magdy Mettias, MD, as their PCP.	36.9%	54.0%	67.0%	*Low Confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART Aim goal rates as 36.9 percent and 54.0 percent, respectively. The SMART Aim goal was achieved in October 2015, with the highest rate, 67.0 percent, achieved in December 2015. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *Diabetes Care* PIP a level of *Low Confidence*. Even though the SMART Aim goal was achieved, none of the implemented interventions could be clearly linked to the demonstrated improvement.

Strengths and Weaknesses

The validation findings suggest that even though 'Ohana QI met the SMART Aim goal for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. Therefore, HSAG assigned a level of *Low Confidence* to both PIPs.

Recommendations for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the improvement strategies used must be methodologically sound and based on solid improvement science. 'Ohana QI's PIP performance suggested a number of areas of opportunity that applied across the various PIP topics. HSAG recommended the following for 'Ohana QI:

- Complete all upfront analyses before testing an intervention. The health plan needs to be able to gauge current performance, compare it to improved performance, and have a method of measuring the difference. By completing the upfront analysis, both objectives can be accomplished.
- Ensure that the interventions are started in a timely manner. If delays occur, the health plan may not have incurred enough data points by the SMART Aim end date.
- Provide weekly or monthly data points showing the data and progress of intervention evaluation over time.
- Ensure that the core PIP team includes analytical staff members who are involved in all data-related processes of the PIP.

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

The following is a summary of the Child CAHPS performance highlights for 'Ohana QI. The performance highlights are broken into two key areas:

- Statewide Comparisons
- NCQA Comparisons

Findings

Table 3-55 presents 'Ohana QI's results from these analyses. For the four global ratings, five composite measures, and two individual item measures, the table depicts 'Ohana QI's trended summary rates[3-19] and statistical testing results (i.e., ▲ or ▼), and the 2016 NCQA National Average.[3-20] Additionally, 'Ohana QI's overall member satisfaction ratings (i.e., star ratings) are displayed below. Caution should be used when evaluating results with less than 100 respondents (i.e., +).

Table 3-55—Child Medicaid CAHPS Results *for* 'Ohana QI

Measure	2015 Rates	2017 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	56.8%	60.4%	★
Rating of All Health Care	54.7%	59.7%	★
Rating of Personal Doctor	65.9%	68.0%	★
Rating of Specialist Seen Most Often	69.0%	73.2%+	★★★★★
Composite Measures			
Getting Needed Care	76.0%	77.6%	★
Getting Care Quickly	84.0%	81.5%	★
How Well Doctors Communicate	90.6%	93.0%	★★★
Customer Service	79.0%	80.3%	★
Shared Decision Making	82.8%	85.8%+	—
Individual Item Measures			
Coordination of Care	80.8%	77.8%	★
Health Promotion and Education	75.6%	76.6%	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.

Statistical Significance Note: ▲ indicates the 2017 score is statistically significantly higher than the 2015 score
▼ indicates the 2017 score is statistically significantly lower than the 2015 score

(+) indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.

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

[3-19] The child population was last surveyed in 2015; therefore, the 2017 CAHPS scores are compared to the corresponding 2015 scores.

[3-20] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

The trend analysis of ‘Ohana QI’s summary measure rates revealed the following:

- ‘Ohana QI’s 2017 score was not statistically significantly higher or lower than the 2015 score on any measure.
- ‘Ohana QI scored at or above the national average on three measures: *Rating of Specialist Seen Most Often, Shared Decision Making,* and *Health Promotion and Education*.

The detailed results of the comparison to NCQA benchmarks highlighted the following:

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

In addition, an evaluation of performance of three beneficiary satisfaction Quality Strategy measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—compared to NCQA’s 2017 Benchmarks and Thresholds for Accreditation[3-21] was performed for ‘Ohana QI. None of the beneficiary satisfaction Quality Strategy measures for ‘Ohana QI met or exceeded the 75th percentile goal.

Strengths

For ‘Ohana QI’s child Medicaid population, only one of the measures met or exceeded the 75th percentile (i.e., *Rating of Specialist Seen Most Often),* and three of the measures met or exceeded the 2016 NCQA child Medicaid national average: *Rating of Specialist Seen Most Often, Shared Decision Making,* and *Health Promotion and Education.*

Areas for Improvement

Based on a comprehensive assessment of ‘Ohana QI’s CAHPS results, seven potential areas for improvement were identified: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, Customer Service,* and *Coordination of Care*. HSAG evaluated each of these areas to determine if certain CAHPS items (i.e., questions) are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as “key drivers” are driving levels of satisfaction with each of the measures. Given that these measures

[3-21] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

are driving members' level of satisfaction with each of the priority areas, 'Ohana QI should consider determining whether or not potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-56 depicts the individual key drivers 'Ohana QI should consider focusing on for each of the potential priority areas for quality improvement.

Table 3-56—'Ohana QI Key Drivers of Satisfaction

Rating of Health Plan
Respondents reported that a doctor or other health provider did not talk about the reasons they might not want their child to take a medicine.
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.
Respondents reported that forms from their child's health plan were often not easy to fill out.
Respondents reported that when their child needed care right away, they did not receive care as soon as they needed it.
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Rating of All Health Care
Respondents reported that a doctor or other health provider did not talk about the reasons they might not want their child to take a medicine.
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that forms from their child's health plan were often not easy to fill out.
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Rating of Personal Doctor
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.
Respondents reported that their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.
Respondents reported that when their child needed care right away, they did not receive care as soon as they needed it.
Getting Needed Care
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.

Getting Care Quickly
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Customer Service
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.
Coordination of Care
Respondents reported that their child's personal doctor did not always listen to them.
Respondents reported that their child's personal doctor did not always spend enough time with them.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about 'Ohana QI's performance in providing quality, accessible, and timely healthcare and services to its members.

Conclusions

In general, 'Ohana QI's performance results illustrate mixed performance across the four EQR activities. While the compliance monitoring review activity revealed that 'Ohana QI has established an operational foundation to support the quality, access, and timeliness of care and service delivery, performance on outcome and process measures shows room for improvement.

'Ohana QI's compliance review showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. The health plan demonstrated high compliance (i.e., 96 percent) with federal and State contract requirements for structure and operations. It also demonstrated a commitment to quality process improvement by closing all its CAPs from the previous year's compliance review. However, while the policies, procedures, and staff were in place to monitor performance and promote quality, access, and timeliness of care, health plan performance indicators and member satisfaction scores were often below the national Medicaid 50th percentile.

Overall, more than three-quarters (81 percent) of 'Ohana QI's measure rates fell below the NCQA national Medicaid 50th percentile across all measurement domains, with 47 percent of the measure rates falling below the 25th percentile. While some measure rates showed improvement from 2016, 'Ohana QI performance suggested that all measurement domains represent areas of improvement. All HEDIS domains, except for the Care for Chronic Conditions domain, had 80 percent or more of their measure rates below the 50th percentile. Overall, only two of the measure rates met the MQD's Quality Strategy targets.

Similarly, 'Ohana QI's CAHPS results suggest lower satisfaction among its members as nearly all measures were at or below the 25th percentile. Only 'Ohana QI's global rating for specialists and composite measure for doctor's communication scored at or above the 50th percentile. 'Ohana QI scored at or above the national average on three measures: *Rating of Specialist Seen Most Often*, *Shared Decision Making*, and *Health Promotion and Education*, but did not meet or exceed any of the three MQD Quality Strategy targets for beneficiary satisfaction.

The results of 'Ohana QI's PIPs indicate a need for ongoing quality improvement training of staff. Performance across the two PIPs showed considerable opportunity for improvement in implementing the PIPS—i.e., *Diabetes Care* and *All-Cause Readmissions.* Both PIPs were assessed as *Low Confidence.* While the validation findings determined that 'Ohana QI met the SMART Aim goals for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. These results suggest that 'Ohana QI continues to have opportunities for improvement in executing the rapid-cycle PIP process. HSAG recommends ongoing QI training specific to the rapid-cycle PIP process to improve the results of State-mandated PIPs.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

Compliance Monitoring Review

Table 3-57 presents the standards and compliance scores for UHC CP QI. For standards I–VI, HSAG evaluated a total of 74 elements for the CY 2017 review period. Each element was scored as *Met*, *Partially Met*, *Not Met,* or *Not Applicable* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

Table 3-57—Standards and Compliance Scores—UHC CP QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	9	0	0	0	100%
III	Credentialing	45	41	34	7	0	4	91%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**75**	**68**	**7**	**0**	**4**	**95%**

***Total # of Elements*:** The total number of elements in each standard.
***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *NA*.
***Total Compliance Score*:** The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Findings

UHC CP QI had a total compliance score of 95 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.

Strengths

Below is a discussion of the strengths, by standard, that were identified during the compliance review.

Provider Selection: UHC CP QI was found to be compliant with 100 percent of the *Provider Selection* standard. UHC CP QI provided policies and procedures, a provider agreement template, and its provider administrative guide that met all the requirements.

UHC CP QI's training presentations and provider newsletters that informed providers about managed care, QUEST Integration (QI), claims, UM, UHC CP QI's quality program, and other health plan operations were comprehensive. UHC CP QI reported that presentations were provided two times per year on each island and had one-on-one contacts with providers with varying frequency based on provider needs.

UHC CP QI's compliance plan, as well as policies and procedures, included all required components, and its FWA policies and procedures and training documents were robust.

Subcontracts and Delegation: UHC CP QI was found to be compliant with 100 percent of the *Subcontracts and Delegation* standard. UHC CP QI had subcontracts for delegation of behavioral healthcare coordination, UM, and claims management to Optum Behavioral Health; nurse line call center services to Optum; and pharmacy network management, pharmacy benefit management, and pharmacy claims management to OptumRx. UHC CP QI also reported subcontracts with LogistiCare for nonemergent transportation and various community case management agencies (CCMAs) for service coordination to members receiving long-term services and supports. (Delegation of credentialing is reported and scored in Standard III—Credentialing.)

Subcontracts submitted for this standard included all required provisions. UHC CP QI provided evidence of having conducted predelegation and annual audits of its delegates and subcontractors reviewed under this standard. For those delegates, UHC CP QI provided evidence of ongoing monitoring which included regular review of reports from subcontractors. UHC CP QI also submitted meeting minutes of its DOC and joint operating committees (JOCs) with delegates.

UHC CP QI's policies and procedures addressed the requirements for submitting subcontracts to MQD for review and approval prior to subcontracting and for providing notice to MQD if terminations of subcontractors are anticipated to materially affect the health plan's ability to fulfill the terms of its contract with MQD.

Credentialing: UHC CP QI was found to be compliant with 91 percent of the *Credentialing* standard, with seven elements scoring *Partially Met*. UHC CP QI's credentialing program was clearly designed to comply with NCQA credentialing standards and guidelines. The health plan's policies and procedures addressed all NCQA standards and, with few exceptions, were implemented as written. UHC CP QI delegated credentialing/recredentialing of practitioners and assessment/reassessment of organizational providers to Optum Behavioral Health for behavioral health providers, and to MDX for all other providers, and provided evidence that it monitored delegated activities by regularly reviewing reports and performing file audits.

Quality Assessment and Performance Improvement: UHC CP QI was found to be compliant with 100 percent of the *Quality Assessment and Performance Improvement* standard. UHC CP QI had local, Hawaii-based staff members involved in its QAPI program and activities, with additional support, leadership, and consultation from its national headquarters (i.e., the National Quality Team and the National Quality Oversight Committee). The QAPI program was supported by numerous policies and procedures guiding expectations for the care and service delivery system, which provided the framework through which monitoring and improvement activities were conducted.

The health plan's comprehensive quality improvement program description included its QAPI organizational structure, roles and responsibilities of individuals as well as of national and regional supports, governance, and committee structure at all levels (i.e., local/Hawaii, regional, and national). Subcommittees, including those responsible for delegation oversight, physician advisory input, UM, and clinical and service quality, provided input to the health plan's quality program. The scope of UHC CP QI's QAPI program activities included quality of care, patient safety, and quality of service; and the planned activities were documented in an annual workplan with major objectives, identification of responsible individuals or groups, and time frames for completion.

The health plan also provided its UM program description, policies and procedures, and UM report examples as evidence of UHC CP QI's ongoing monitoring of its service utilization patterns and detection of over- and underutilization.

Health Information Systems: UHC CP QI was found to be compliant with 100 percent of the *Health Information Systems* standard. The health plan had Hawaii-based IS staff and national corporate support for the management of all operations related to development and maintenance of its health information systems. Certain delegated functions were outside UHC CP QI's IS structure and required the delegates to collect and report data to UHC CP QI (i.e., MDX for credentialing and LogistiCare for transportation services). The delegates received oversight and periodic audits from the health plan to ensure data validity and completeness. The delegates were also required to maintain data security procedures and disaster recovery processes.

The health plan's on-site interview responses, flow diagrams, and system demonstrations provided evidence of its ability to collect and report information on grievances and appeals, service utilization, member and provider characteristics, and disenrollments, among others. UHC CP QI also had processes in place to verify completeness of its service data by examining and comparing monthly paid claims volume by product line. The health plan ensured validity of services by selecting a 25 percent random sample of paid claims (approximately 4,500–5,000 each month) and providing the member with service information (i.e., date, provider, service, or visit type) so that if the member did not agree that the service had been provided, he or she could contact the health plan.

In addition, data security measures and health information privacy were highlighted during the discussions and supported by policies. UHC CP QI had corporate-level (i.e., United Health Group [UHG]) policies and plans related to disaster planning and recovery and business continuity, as well as local-level procedures depicting Hawaii leadership roles and responsibilities in the event of a disaster.

Practice Guidelines: UHC CP QI was found to be compliant with 100 percent of the *Practice Guidelines* standard. The UHG national committee structure is primarily responsible for the selection, review, and adoption of CPG topics and conditions. Selection and review by three UHG national committees (i.e., Medical Technology Assessment Committee, National Medical Care Management Committee, and National Quality Oversight Committee) ensures that only nationally recognized guidelines or consensus documents are adopted. The local Hawaii health plan, UHC CP QI, participates in the national process and determines the relevance of these CPGs for its populations and conditions.

UHC CP QI manages practice guideline adoption and dissemination through its Hawaii-based clinical leadership staff. The health plan has selected and disseminated numerous CPGs, including those addressing medical and behavioral health conditions, preventive services, and certain social situations (e.g., identifying and treating violence and abuse). CPGs are disseminated to providers online via links on UHC CP QI's provider portal and through newsletters and other mailings.

Areas for Improvement

Below is a discussion of the areas for improvement, by standard, that were identified during the compliance review, and subject to implementation of a CAP.

Subcontracts and Delegation: Although HSAG identified no areas requiring corrective action for this standard, HSAG provided the following suggestion for improvement. UHC CP QI may want to consider extending the above-described successful delegation oversight processes to the area of credentialing delegation.

During the second day of the on-site review, UHC CP QI reported that an affiliated entity performs oversight of UHC CP QI's credentialing delegates on its behalf. Although not provided initially in the desk review documentation, HSAG learned that United Healthcare Insurance Company (UHIC), doing business as UHC CP QI in Hawaii, holds a Management Services Agreement (MSA) with UnitedHealthcare Services, Inc. (UHS), another affiliate of UHG. The health plan reported that UHC CP QI is not a separate legal entity from UHS; however, this MSA suggests that the relationship between UHC CP QI and UHS is a delegation agreement and therefore requires oversight by the health plan under the federal managed care regulations. (See Section 1.2 and Exhibit A of the MSA regarding UHC CP QI's duty to oversee the provided services and the list of delegated services, respectively.) This functional relationship is similar to the delegation agreements UHC CP QI has established with other affiliates under the UHG parent company (e.g., Optum Behavioral Health and OptumRx). ***HSAG strongly recommends that UHC CP QI review and determine whether its relationship with UHS is a delegation of UHC CP QI's credentialing delegation oversight obligation and consider expanding its oversight monitoring processes to the services that UHS provides for UHC CP QI***. HSAG noted that some of the corrective actions required in Standard III appear to be related to the quality of delegation oversight provided by UHS on UHC CP QI's behalf.

Credentialing: Although UHC CP QI provided evidence that credentialing activities were completed according to NCQA standards and guidelines, UHC CP QI's process was not well-defined in its documents, and the policy was difficult to follow with confounding references. ***UHC CP QI must revise policies and documents that describe UHC CP QI's credentialing process to correct inconsistencies between documents and clearly describe the process.***

The submitted UnitedHealthcare Credentialing Plan described the UHC National Credentialing Center's (NCC's) process for making decisions; however, the UHC CP QI Credentialing policy described decision making by the health plan's delegates. During the on-site interviews, staff members' responses were inconsistent in reporting how credentialing decisions were made. Further, review of the health plan's provider advisory committee meeting minutes revealed that credentialing decisions are being

made by the delegates (as permitted by NCQA standards and guidelines), and that the committee reviewed a quarterly report containing only the number of credentialed and recredentialed providers, with no detail of the delegates' discussions. ***UHC CP QI must revise applicable documents and processes for consistency and clarity and must ensure staff members understand roles and responsibilities of delegates, national and local committees, and health plan staff.***

The Credentialing Plan and the Credentialing Policy delineated conflicting processes. ***UHC CP QI must revise existing documents or develop new policies and procedures that clearly and consistently describe processes used to manage credentialing files.*** If variations exist between the national plan and the health plan policy, UHC CP QI must articulate which process supersedes the other.

UHC CP QI's credentialing policy stated that UHC CP QI's delegates will conduct a site visit for nonaccredited facilities. The policy also stated that delegates may not substitute a CMS or State review or certification in lieu of the site visit unless the delegate has reviewed the certification requirements and validated that they meet NCQA and UHC CP QI standards. During the on-site interview, UHC CP QI staff members reported that a State license or certification is accepted in lieu of the site visit with the assumption that if the license or certification was awarded, a site visit would have been conducted. ***UHC CP QI must develop a mechanism to ensure State or CMS surveys meet the health plan's criteria for on-site quality assessment and for accepting such survey in lieu of a UHC CP QI (or delegate) on-site visit for organizational providers that are not accredited.*** If UHC CP QI chooses to accept a CMS or State survey, it must ensure that the survey accepted in lieu of the site visit meets the health plan's standards for on-site quality assessment by comparing the CMS or State survey to UHC CP QI's or the delegate's site visit form or establishing a threshold for the survey that UHC CP QI will accept for participation in the network (for example, a percentage score or maximum number of deficiencies allowed).

While UHC CP QI provided evidence of receiving quarterly reports from MDX, no examples of regular reports from Optum Behavioral Health were submitted for HSAG's compliance review activities. During the on-site review, UHC CP QI staff members reported that ongoing monitoring for Optum Behavioral Health was accomplished through a JOC, but meeting minutes did not demonstrate a review of the credentialing tasks delegated to Optum Behavioral Health. ***UHC CP QI must regularly review credentialing activity reports from Optum Behavioral Health, its delegate for credentialing and recredentialing behavioral health providers.***

UHC CP QI provided the 2016 annual audit reports for MDX and for Optum Behavioral Health. The MDX audit included Hawaii provider files audited for compliance with NCQA requirements. The Optum Behavioral Health audit included provider files from a variety of states; however, it included no Hawaii provider files in the sample reviewed. As such, Optum Behavioral Health was not audited for credentialing and recredentialing of UHC CP QI's behavioral health practitioners and organizational providers in Hawaii. In addition, UHC CP QI's 2011 compliance review report (the last year in which HSAG reviewed the *Credentialing* standard) included a required action related to this same finding. UHC CP QI's planned intervention statement was as follows: "The delegation audit of UBH [United Behavioral Health] credentialing performed during July 2011 included Hawaii files as part of its review.

Future audits will also contain Hawaii files." ***UHC CP QI must ensure that UHC CP QI credentialing and recredentialing files are audited annually against NCQA standards.***

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated UHC CP QI'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 QI was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that UHC CP QI had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. UHC CP QI elected to use six standard and four nonstandard supplemental data sources for its performance measure reporting. During the validation process of these supplemental data sources, no significant errors were discovered. All convenience samples passed HSAG's review.

Most of the QI measures which UHC CP QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted for the measure. Four measures received an *NA* designation due to small denominators—i.e., *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Medication Management for People With Asthma,* and *Follow-Up Care for Children Prescribed ADHD Medication.* Additionally, two measures were found to be materially biased and received a *Biased Rate* designation—i.e., *Follow-Up After Emergency Department Visit for Mental* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence*. UHC CP QI experienced no enrollment complications related to properly identifying these members on the daily and monthly enrollment files. Eligibility was properly identified within its enrollment system. UHC CP QI passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Controlling High Blood Pressure*
- Group B: Anticipatory Guidance & Counseling—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 1*
- Group F: Exclusions—*All Medical Record Exclusions*

Access to Care Performance Measure Results

UHC CP QI's Access to Care performance measure results are shown in Table 3-58. None of the rates in this domain reported a significant improvement of more than 5 percentage points. One measure rate was at or above the national Medicaid 90th percentile; two measure rates were between the 50th percentile and 75th percentile; and the remaining seven measure rates were below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2017.

Table 3-58—UHC CP QI's HEDIS Results for QI Measures Under Access to Care

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	63.62%	58.08%	-5.54	★
45–64 Years	82.84%	79.37%	-3.47	★
65 Years and Older	92.80%	94.46%	1.66	★★★★★
Total	79.91%	76.01%	-3.90	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	88.40%	91.55%	3.15	★
25 Months–6 Years	77.27%	74.73%	-2.54	★
7–11 Years	85.53%	82.46%	-3.07	★
12–19 Years	82.43%	79.34%	-3.09	★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	36.99%	42.62%	5.63	★★★
Engagement of AOD Treatment	8.63%	10.36%	1.73	★★★

2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Children's Preventive Health Performance Measure Results

UHC CP QI's Children's Preventive Health performance measure results are shown in Table 3-59. Three of the measure rates in this domain reported a significant improvement of more than 5 percentage points in 2017 (i.e., *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* [all three rates]). Additionally, four measure rates were at or above the national Medicaid 50th percentile, with one of these measure rates at or above the 75th percentile but below the 90th percentile. The remaining measures were below the 25th percentile. There was one measure in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Childhood Immunization Status—Combination 3*), and UHC CP QI did not reach the established target, the 75th percentile.

Table 3-59—UHC CP QI's HEDIS Results for QI Measures Under Children's Preventive Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	34.31%	36.98%	2.67	★

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	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Childhood Immunization Status				
Combination 3	61.79%	55.65%	-6.14	★
Hepatitis B	80.36%	76.86%	-3.50	★
HiB	80.00%	77.41%	-2.59	★
IPV	81.79%	76.58%	-5.21	★
MMR	79.29%	76.58%	-2.71	★
Pneumococcal Conjugate	65.71%	60.33%	-5.38	★
VZV	78.21%	74.66%	-3.55	★
Immunizations for Adolescents				
Combination 1	41.41%	34.38%	-7.03	★
Combination 2	—	4.69%	—	—
HPV	—	5.73%	—	—
Meningococcal	43.75%	37.50%	-6.25	★
Tdap	45.31%	40.10%	-5.21	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	5.99%	4.11%	-1.88	★
Six or More Well-Child Visits	59.51%	61.88%	2.37	★★★
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	60.10%	61.07%	0.97	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	73.24%	79.32%	6.08	★★★★
Counseling for Nutrition—Total	60.34%	65.21%	4.87	★★★
Counseling for Physical Activity—Total	51.34%	58.64%	7.30	★★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.

2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.

3- Differences are not reported if the 2016 rate is not reported.

4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Women's Health Performance Measure Results

UHC CP QI's Women's Health performance measure results are shown in Table 3-60. While six of the rates in this domain reported a significant improvement of more than 5 percentage points, only the *Breast Cancer Screening* rate was at or above the national Medicaid 50th percentile but below the 75th percentile. The remaining measures were below the 50th percentile, with the *Cervical Cancer Screening* and *Postpartum Care* measures falling below the 25th percentile. There were four measures in this domain with MQD Quality Strategy targets for HEDIS 2017 (i.e., *Breast Cancer Screening, Cervical Cancer Screening, Frequency of Ongoing Prenatal Care,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*); however, none of UHC CP QI's measure rates met or exceeded the established Quality Strategy targets.

Table 3-60—UHC CP QI's HEDIS Results for QI Measures Under Women's Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	56.64%	62.02%	5.38	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	48.18%	43.80%	-4.38	★
Chlamydia Screening in Women				
16–20 Years	38.10%	50.31%	12.21	★★
21–24 Years	47.88%	55.90%	8.02	★★
Total	45.26%	54.26%	9.00	★★
Frequency of Ongoing Prenatal Care				
*<21 Percent of Expected Visits**	24.78%	14.66%	-10.12	★★
≥81 Percent of Expected Visits	32.45%	47.64%	15.19	★★
Prenatal and Postpartum Care				
Postpartum Care	50.44%	54.97%	4.53	★
Timeliness of Prenatal Care	68.73%	78.80%	10.07	★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Care for Chronic Conditions Performance Measure Results

UHC CP QI's Care for Chronic Conditions performance measure results are shown in Table 3-61. Although only one of the measure rates (i.e., *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* in this domain reported a significant improvement of more than 5 percentage points, 12 of the measure rates were at or above the national Medicaid 50th percentile. Five measure rates were at or above the 75th percentile and below 90th percentile, and one measure rate (i.e., *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*) was at or above the 90th percentile. Two measure rates were at or above the 25th percentile and below the 50th percentile. There were eight measures[3-22] in this domain with MQD Quality Strategy targets for HEDIS 2017, and four of UHC CP QI's measure rates met or exceeded the established Quality Strategy targets (i.e., *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, Comprehensive Diabetes Care—HbA1c Control (<8.0%),* and *Medication Management for People with Asthma—50% and 75% Compliant).*

Table 3-61—UHC CP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	91.70%	91.80%	0.10	★★★★
Annual Monitoring for Members on Digoxin	52.03%	51.69%	-0.34	★★
Annual Monitoring for Members on Diuretics	92.07%	91.88%	-0.19	★★★★
Total	90.97%	91.18%	0.21	★★★★
Comprehensive Diabetes Care				
Blood Pressure Control (<140/90 mm Hg)	59.51%	65.20%	5.69	★★★
Eye Exam (Retinal) Performed	69.79%	69.60%	-0.19	★★★★★
HbA1c Control (<7.0%)	33.82%	32.75%	-1.07	★★
HbA1c Control (<8.0%)	51.03%	50.72%	-0.31	★★★
*HbA1c Poor Control (>9.0%)**	41.65%	38.48%	-3.17	★★★
Hemoglobin A1c (HbA1c) Testing	85.84%	86.64%	0.80	★★★

[3-22] Within this domain, there are eight MQD Quality Strategy targets: *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, and Blood Pressure Control (<140/90 mm Hg); Controlling High Blood Pressure*, and *Medication Management for People with Asthma* (two rates).

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Medical Attention for Nephropathy	90.78%	91.36%	0.58	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	63.50%	61.98%	-1.52	★★★
Medication Management for People With Asthma				
Medication Compliance 50%—Total	62.81%	63.45%	0.64	★★★★
Medication Compliance 75%—Total	42.21%	40.61%	-1.60	★★★★

** For this indicator, a lower rate indicates better performance.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Behavioral Health Performance Measure Results

UHC CP QI's Behavioral Health performance measure results are shown in Table 3-62. Of the four measure rates reported previously in 2016, two measures exhibited a significant improvement of more than 5 percentage points. Three measure rates were at or above the 50th percentile, and two of these measure rates were at or above the 75th percentile but below the 90th percentile. Two measures were at or above the 25th percentile and below the 50th percentile. There is one measure in this domain with an MQD Quality Strategy target for HEDIS 2017 (i.e., (*Follow-Up After Hospitalization for Mental Illness)*, and UHC CP QI met or exceeded the established target for both indicator rates, the 75th percentile.

Table 3-62—UHC CP QI's HEDIS Results for QI Measures Under Behavioral Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	61.88%	52.38%	-9.50	★★
Effective Continuation Phase Treatment	48.51%	39.38%	-9.13	★★★
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia				
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	—	NA	—	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	78.22%	—	★★
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
30 Days—13–17 Years	—	NA	—	—
30 Days—18+ Years	—	33.40%	—	—
30 Days—Total	—	33.47%	—	—
7 Days—13–17 Years	—	NA	—	—
7 Days—18+ Years	—	28.07%	—	—
7 Days—Total	—	28.02%	—	—
Follow-Up After Emergency Department Visit for Mental Illness				
30-Day Follow-Up	—	72.10%	—	—
7-Day Follow-Up	—	64.01%	—	—
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	62.96%	72.68%	9.72	★★★★
7-Day Follow-Up	41.98%	59.02%	17.04	★★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	NA	—	NA
Continuation and Maintenance Phase	—	NA	—	NA

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Follow-up With Assigned PCP Following Hospitalization for Mental Illness**				
*Follow-up With Assigned PCP Following Hospitalization for Mental Illness***	—	6.70%	—	—

*** Non-HEDIS state-defined measure; rates were reported using an MS Excel reporting template.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.
A "NA" value indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30 cases) to report a valid rate, resulting a small denominator (NA) audit designation. It is also used to indicate when star ratings are not applicable.
A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:
1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Utilization and Health Plan Descriptive Information Performance Measure Results

UHC CP QI's Utilization and Health Plan Descriptive Information performance measure results are shown in Table 3-63. Utilization of more or fewer services is not indicative of performance; therefore, it is inappropriate to compare these rates to national Medicaid benchmarks. Of the measure rates reported previously in 2016, few measures exhibited a significant change in performance in 2017. Moreover, the *Ambulatory Care—ED Visits per 1,000 Member Months* measure failed to meet the MQD Quality Strategy target—i.e., 90th percentile.

Table 3-63—UHC CP QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	59.38	61.01	1.63	★★★
Outpatient Visits—Total	499.16	556.18	57.02	—
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	—	20.53%	—	—

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
20–44 Years Subtotal Percentage—Total	—	32.47%	—	—
45–64 Years Subtotal Percentage—Total	—	25.53%	—	—
65+ Years Subtotal Percentage—Total	—	21.47%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
Maternity—Average Length of Stay—Total	2.46	2.48	0.02	—
Maternity—Days per 1,000 Member Months—Total	3.99	4.29	0.30	—
Maternity—Discharges per 1,000 Member Months—Total	1.62	1.73	0.11	—
Medicine—Average Length of Stay—Total	4.15	5.41	1.26	—
Medicine—Days per 1,000 Member Months—Total	27.09	27.62	0.53	—
Medicine—Discharges per 1,000 Member Months—Total	6.52	5.11	-1.41	—
Surgery—Average Length of Stay—Total	7.20	10.57	3.37	—
Surgery—Days per 1,000 Member Months—Total	23.49	28.72	5.23	—
Surgery—Discharges per 1,000 Member Months—Total	3.26	2.72	-0.54	—
Total Inpatient—Average Length of Stay—Total	4.91	6.60	1.69	—
Total Inpatient—Days per 1,000 Member Months—Total	53.16	59.20	6.04	—
Total Inpatient—Discharges per 1,000 Member Months—Total	10.83	8.97	-1.86	—
Mental Health Utilization				
Any Service—Total	12.50%	11.71%	-0.79	—
Inpatient—Total	0.67%	0.58%	-0.09	—
Intensive Outpatient or Partial Hospitalization—Total	0.04%	0.03%	-0.01	—

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Outpatient, ED, or Telehealth—Total	12.24%	11.49%	-0.75	—
Plan All-Cause Readmissions				
*Plan All-Cause Readmissions****	11.70%	10.71%	-0.99%	★★★★

** For this indicator, a lower rate indicates better performance.*
**** Measure was not available for Medicaid IDSS reporting; rates were reported using an MS Excel reporting template. The Medicare benchmark was used for the comparison to national percentile scoring.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Conclusions and Recommendations

Based on HSAG's analyses of those UHC CP QI's measure rates with comparable benchmarks, nearly 20 percent of UHC CP QI's measure rates (11 of 57 rates) were at or above the national Medicaid 75th percentile, with two measures at or above the national Medicaid 90th percentile in 2017. An additional 14 measure rates were at or above the 50th percentile but below the 75th percentile, indicating moderate performance related the Care for Chronic Conditions domains. Moreover, UHC CP QI met or exceeded the MQD Quality Strategy target for seven measures in 2017: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, HbA1c Control (<8.0%), and HbA1c Poor Control (>9.0%); Medication Management for People With Asthma* (both rates)*, and Follow-Up After Hospitalization for Mental Illness* (both rates).

Conversely, most of those UHC CP QI's rates that were comparable to national benchmarks (22 of 56 rates) ranked below the national Medicaid 25th percentile in 2017, suggesting considerable opportunities for improvement across all domains of care. HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services* (three rates)
  - *Children and Adolescents' Access to Primary Care Practitioners* (four rates)

- Children's Preventive Care
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status* (seven rates)
  - *Immunizations for Adolescents* (three rates)
  - *Well-Child Visits in the First 15 Months of Life* (one rate)
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- Women's Health
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care* (one rate)

Validation of Performance Improvement Projects

For validation year 2017, UHC CP QI submitted two State-mandated PIP topics for validation: *All-Cause Readmissions* and *Diabetes Care.* The *All-Cause Readmissions* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality, timeliness of, and access to care and services. The focus of the PIP was to decrease the rate of readmissions within 30 days for members 18 to 64 years of age assigned to Kalihi-Palama Health Center (KPHC). The *Diabetes Care* PIP topic addressed CMS' requirements related to quality outcomes—specifically, quality of and access to care and services. The focus of the PIP was to increase the percentage of Bay Clinic members with diabetes with at least one HbA1c test in the past 12 months. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Findings

HSAG organized and analyzed UHC CP QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal.

For each PIP, UHC CP QI was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. UHC CP QI developed a SMART Aim statement that quantified the improvement sought for each PIP. HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence, Confidence,* and *Low Confidence*. Table 3-64 outlines the PIP topics, final reported SMART Aim statements, and the overall validation findings for the two PIPs.

Table 3-64—PIP Topic, SMART Aim Statements, and Confidence Levels for UHC CP QI

PIP Topic	SMART Aim Statement	Confidence Level
All-Cause Readmissions	By December 31, 2016, decrease the rate of readmissions from acute inpatient stays among UnitedHealthcare members who are not dually enrolled with Medicare.	*Low Confidence*
Diabetes Care	By December 31, 2016, increase the percentage of members with diabetes aged 18–75 years with no more than one gap in enrollment of up to 45 days in the past 12 months with Bay Clinic as their primary care provider (PCP) who have had at least one HbA1c test, from 69.7% to 80.2%.	*Confidence*

HSAG assigned the level of *Low Confidence* to UHC CP QI's *All-Cause Readmissions* PIP and assigned the level of *Confidence* for the *Diabetes Care* PIP. Although the SMART Aim goal was achieved for both PIPs, none of the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement for the *All-Cause Readmissions* PIP; only one intervention was clearly linked to improvement for the *Diabetes Care* PIP.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

All-Cause Readmissions PIP

UHC CP QI's focus for this PIP was to identify and test interventions to decrease the rate of eligible members readmitted to the hospital within 30 days of a hospital discharge from KPHC. Although the health plan achieved the SMART Aim goal of the PIP, this success could not be clearly linked to the tested interventions. HSAG assigned a level of *Low Confidence* to this PIP. The details of the PIP's performance leading to the assigned confidence level are described below.

The health plan's rationale for selecting KPHC as the targeted facility for the PIP, and the PIP's initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. UHC CP QI implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *All-Cause Readmissions* PIP are presented in Table 3-65.

Table 3-65—UHC CP QI's Intervention Testing for *All-Cause Readmis*sions PIP

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Provider assignment improvement	• Timely identification of acute inpatient stays. • Identification of patients at risk of readmission.	The patient is not accessible after discharge for outreach to complete post-discharge activities.	The health plan chose to **adapt** this intervention.
Develop a program to find inaccessible patients in the community	Access to current member demographic information	The patient is not accessible after discharge for outreach to complete post-discharge activities	The health plan chose to **abandon** this intervention.

HSAG validated UHC CP QI**'s** *All-Cause Readmissions* PIP SMART Aim measure rates based on the SMART Aim run chart in Module 5. Table 3-66 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 3-66—UHC CP QI's SMART Aim Measure Results for All-Cause Readmissions PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
Readmissions rate for KPHC's non-dually enrolled members	19.6%	16.7%	0%	*Low Confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART aim goal rates as 19.6 percent and 16.7 percent, respectively. The health plan achieved the SMART Aim goal and remained below the goal throughout the life of the PIP. The lowest SMART Aim measure rate, 0 percent, was achieved in both February and July 2016. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *All-Cause Readmissions* PIP a level of *Low Confidence* because even though the SMART Aim goal was achieved, none of the interventions could be clearly linked to the demonstrated improvement.

Diabetes Care PIP

The focus of UHC CP QI**'s** *Diabetes Care* PIP was to identify and test interventions to increase the percentage of Bay Clinic members with diabetes who had at least one hemoglobin A1c (HbA1c) test in the past 12 months. The health plan met the SMART Aim goal for the PIP, and one of the interventions tested was clearly linked to the improvement in the SMART Aim measure rate. HSAG assigned a level of *Confidence* to the PIP. The details of the PIP's performance leading to the assigned confidence level are described below.

The health plan's rationale for selecting Bay Clinic as the targeted focus for the PIP, and the PIP's initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. UHC CP QI implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *Diabetes Care* PIP are presented in Table 3-67.

Table 3-67—UHC CP QI's Intervention Testing for Diabetes Care PIP

Intervention	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Identify diabetics who are due for HbA1c testing	• Lack of member engagement with the healthcare provider regarding diabetes. • PCP communication to members regarding the need for HbA1c testing and HbA1c level.	• The patient is not identified as being due for an HbA1c test. • The patient is not identified as being diabetic.	The health plan chose to adopt this intervention.
Community-based outreach collaboration between the health plan and Bay Clinic	• Service coordination. • Lack of member engagement with the healthcare provider regarding diabetes.	• The patient is not accessible for outreach. • The patient does not have available transportation to go to the clinic.	The health plan chose to abandon this intervention.

HSAG validated UHC CP QI's *Diabetes Care* PIP performance based on rates that the health plan plotted on the SMART Aim run chart in Module 5. Table 3-68 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 3-68—UHC CP QI's SMART Aim Measure Results for Diabetes Care PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Percentage of diabetic members with no more than one gap in enrollment of up to 45 days in the past 12 months with Bay Clinic as their PCP who have at least one HbA1c test	69.7	80.2	82.4	*Confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART Aim goal rates as 69.7 percent and 80.2 percent, respectively. The SMART Aim goal was achieved in March 2016, with the highest rate, 82.4 percent, achieved in August 2016. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *Diabetes Care* PIP a level of *Confidence*. Even though the SMART Aim goal was achieved, only one of the implemented interventions could be linked to the demonstrated improvement.

Strengths and Weaknesses

The validation findings suggest that for the *All-Cause Readmissions* PIP, the health plan achieved the SMART Aim goal, but the quality improvement processes and interventions could not be linked to the improvement. The downward trend in the SMART Aim measure rate began before the interventions were implemented. Therefore, HSAG assigned the health plan a level of *Low Confidence* to the PIP.

UHC CP QI demonstrated partial success in executing the rapid-cycle *Diabetes Care* PIP. The PIP was methodologically sound and achieved the SMART Aim for the measure, but there was not a clear link between all quality improvement processes and the demonstrated improvement. Only the first intervention, which involved identifying diabetics who are due for HbA1c testing, could be clearly linked to the demonstrated improvement. The second intervention, related to community-based outreach collaboration between the health plan and Bay Clinic, could not be executed and tracked as planned due to staffing issues, and hence could not be linked to improvement. HSAG assigned a level of *Confidence* to the *Diabetes Care* PIP.

Areas for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the improvement strategies used must be methodologically sound and based on solid improvement science. UHC CP QI's PIP performance suggested several areas of opportunity that applied across the various PIP topics. HSAG recommended the following for UHC CP QI:

- Prepare provider partners regarding the resources, required logistics, and processes to successfully test an intervention.
- Ensure that the interventions are started in a timely manner. If delays occur, the health plan may not have incurred enough data points by the SMART Aim end date.

- Provide weekly or monthly data points showing the data and progress of intervention evaluation over time.
- Ensure that the core PIP team includes analytical staff members who that are involved in all data-related processes of the PIP.
- Consider testing interventions in multiple environments before adoption.

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

The following is a summary of the Child CAHPS performance highlights for UHC CP QI. The performance highlights are broken into two key areas:

- Statewide Comparisons
- NCQA Comparisons

Findings

Table 3-69 presents UHC CP QI's results from these analyses. For the four global ratings, five composite measures, and two individual item measures, the table depicts UHC CP QI's trended summary rates[3-23] and statistical testing results (i.e., ▲ or ▼), and the 2016 NCQA National Average.[3-24] Additionally, UHC CP QI's overall member satisfaction ratings (i.e., star ratings) are displayed below. Caution should be used when evaluating results with less than 100 respondents (i.e., +).

Table 3-69—Child Medicaid CAHPS Results *for* UHC CP QI

Measure	2015 Rates	2017 Rates	Star Ratings
Global Ratings			
Rating of Health Plan	61.1%	66.3%	★★
Rating of All Health Care	62.9%	60.2%	★★★
Rating of Personal Doctor	77.0%	70.5%	★★★
Rating of Specialist Seen Most Often	78.7%+	75.9%	★★★★★
Composite Measures			
Getting Needed Care	82.8%	81.5%	★
Getting Care Quickly	84.9%	81.6%	★
How Well Doctors Communicate	93.0%	93.5%	★★★
Customer Service	82.1%	85.2%	★
Shared Decision Making	78.5%+	85.8%+	—

[3-23] The child population was last surveyed in 2015; therefore, the 2017 CAHPS scores are compared to the corresponding 2015 scores.

[3-24] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

Measure	2015 Rates	2017 Rates	Star Ratings
Individual Item Measures			
Coordination of Care	84.7%+	85.0%	★★★
Health Promotion and Education	81.0%	75.0%	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.

Statistical Significance Note: ▲ indicates the 2017 score is statistically significantly higher than the 2015 score
▼ indicates the 2017 score is statistically significantly lower than the 2015 score

(+) indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.

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

The trend analysis of UHC CP QI's summary measure rates revealed the following:

- UHC CP QI did not score statistically significantly higher or lower in 2017 than in 2015 on any measure.
- UHC CP QI scored at or above the national average on five measures: *Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.

The detailed results of the comparison to NCQA benchmarks highlighted the following:

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

In addition, an evaluation of performance of three beneficiary satisfaction Quality Strategy measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—compared to NCQA's 2017 Benchmarks and Thresholds for Accreditation[3-25] was performed for UHC CP QI. None

[3-25] National Committee for Quality Assurance. HEDIS Benchmarks and Thresholds for Accreditation 2017. Washington, DC: NCQA, May 4, 2017.

of the beneficiary satisfaction Quality Strategy measures for UHC CP QI met or exceeded the 75th percentile goal.

Strengths

For UHC CP QI's child Medicaid population, only one of the measures met or exceeded the 75th percentile (i.e., *Rating of Specialist Seen Most Often),* and five of the measures met or exceeded the 2016 NCQA child Medicaid national average: *Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*. Six measure rates were less than the 2016 NCQA child Medicaid national averages.

Areas for Improvement

Based on a comprehensive assessment of UHC CP QI's CAHPS results, three potential areas for improvement were identified: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. HSAG evaluated each of these areas to determine if certain CAHPS items (i.e., questions) are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers" are driving levels of satisfaction with each of the three measures. Given that these measures are driving members' level of satisfaction with each of the priority areas, UHC CP QI should consider determining whether potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-70 depicts the individual key drivers UHC CP QI should consider focusing on for each of the potential priority areas for quality improvement.

Table 3-70—UHC CP QI Key Drivers of Satisfaction

Getting Needed Care
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.
Respondents reported that it was often not easy for their child to obtain appointments with specialists.
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Getting Care Quickly
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.
Customer Service
Respondents reported that their child's health plan's customer service did not always give them the information or help they needed.
Respondents reported that forms from their child's health plan were often not easy to fill out.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about UHC CP QI's performance in providing quality, accessible, and timely healthcare and services to its members.

Conclusions

In general, UHC CP QI's performance results illustrate moderate performance across the four EQR activities. While the compliance monitoring review activity revealed that UHC CP QI has established an operational foundation to support the quality, access, and timeliness of care and service delivery, performance on outcome and process measures shows moderate performance and some room for improvement.

UHC CP QI's compliance review showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. The health plan demonstrated high compliance (i.e., 95 percent) with federal and State contract requirements for structure and operations. UHC CP QI also demonstrated a commitment to quality process improvement by closing all its CAPs from the previous year's compliance review. However, while the policies, procedures, and staff were in place to monitor performance and promote quality, access, and timeliness of care, health plan performance indicators and member satisfaction scores were mixed.

Overall, just over half (56 percent) of UHC CP QI's measure rates fell below the NCQA national Medicaid 50th percentile across all measurement domains, with 39 percent of the measure rates falling below the 25th percentile. While some measure rates showed improvement from 2016, UHC CP QI's performance suggested that all measurement domains represent areas of improvement. Except for the Care for Chronic Conditions, Behavioral Health, and Utilization domains, more than two-thirds of the measure rates in the remaining HEDIS domains were below the 50th percentile. Overall, seven measure rates met the MQD's Quality Strategy targets.

Similarly, UHC CP QI's CAHPS results suggest moderate satisfaction among its members, with more than 50 percent of the global ratings, composite measures, and individual measures performing at or above the 50th percentile. Moreover, UHC CP QI scored at or above the national average on five measures: *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education.* UHC CP QI did not meet or exceed any of the three MQD Quality Strategy targets for beneficiary satisfaction.

The results of UHC CP QI's PIPs indicate a need for ongoing quality improvement training of staff. HSAG assessed UHC CP QI's *All-Cause Readmissions* PIP with *Low Confidence* but assessed its *Diabetes Care* PIP with *Confidence.* While the validation findings determined that UHC CP QI met the SMART Aim goals for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. These results suggest that UHC CP continues to have opportunities for improvement in executing the rapid-cycle PIP process. HSAG recommends ongoing QI training specific to the rapid-cycle PIP process to improve results of State-mandated PIPs.

‘Ohana Community Care Services (‘Ohana CCS) Results

Compliance Monitoring Review

Table 3-71 presents the standards and compliance scores for ‘Ohana CCS. For standards I–VI, HSAG evaluated a total of 76 elements for the CY 2017 review period. Each element was scored as *Met*, *Partially Met*, *Not Met,* or *Not Applicable* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

Table 3-71—Standards and Compliance Scores—‘Ohana CCS

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	9	0	0	0	100%
III	Credentialing	44	40	35	5	0	4	94%
IV	Quality Assessment and Performance Improvement	8	8	7	1	0	0	94%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**80**	**76**	**70**	**6**	**0**	**4**	**96%**

***Total # of Elements*:** The total number of elements in each standard.
***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *NA*.
***Total Compliance Score*:** The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Findings

‘Ohana CCS had a total compliance score of 96 percent with four of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.

Strengths

Below is a discussion of the strengths, by standard, that were identified during the compliance review.

Provider Selection: ‘Ohana CCS was found to be compliant with 100 percent of the *Provider Selection* standard. ‘Ohana CCS demonstrated that it effectively used its provider manual and, periodically, the quarterly provider newsletters to regularly communicate to providers a member’s rights to participate in care decisions and receive information about treatments (including alternative treatments), and the benefits and risks of receiving or not receiving treatment.

'Ohana CCS' policies and procedures regarding developing and maintaining the network of providers included all required provisions as did the provider agreement templates. Initial provider orientation and training included an array of information about the behavioral health organization (BHO) including health plan operations, organizational structure, benefit packages, coding procedures, billing procedures, disease management and other member programs, 'Ohana's health plan and its relationship to the BHO, member rights, grievance and appeal processes, communication tips, and how to participate in the UM and quality management (QM) programs.

The BHO's compliance plan was a WellCare corporate document, was comprehensive, and addressed each of the required provisions. Policies and procedures provided Hawaii-specific processes related to compliance training; communication; and reporting of compliance issues and suspected FWA. 'Ohana Health Plan and 'Ohana CCS shared a compliance officer and provided evidence of ongoing communication and messaging to staff members, providers, and members, and of regular compliance committee meetings.

Subcontracts and Delegation: 'Ohana CCS was found to be compliant with 100 percent of the *Subcontracts and Delegation* standard. 'Ohana CCS had clear processes for oversight and monitoring of subcontracted delegates. The BHO's policies and procedures, contract templates, DOC meeting minutes, as well as examples of completed audits demonstrated CCS' processes designed to maintain responsibility for all delegated tasks.

'Ohana CCS had several delegation agreement templates based on the type of administrative activity being delegated. Policies and procedures, all delegation contract templates, as well as the agreement that was newly executed during the review period, included all required provisions. In addition to annual auditing (formal review), the BHO required regular status reports based on the activity delegated, as well as self-reported compliance with requirements of the contract using electronic scorecards via the Compliance 360 software program.

HSAG found the BHO's practices regarding what was considered to be a delegated activity to be effective and in compliance. However, it was noted that the BHO may want to consider consulting the NCQA *Standards and Guidelines for the Accreditation of Managed Behavioral Health Organizations* publication to determine if following the credentialing standards for assessment of organizational providers may be more applicable and cost-effective in some cases (e.g., when a facility such as a hospital or clinic credentials its own practitioners).

Credentialing: 'Ohana CCS was found to be compliant with 94 percent of the *Credentialing* standard, with six elements scoring *Partially Met*. 'Ohana CCS, through its WellCare office in Tampa, had effective operational processes for credentialing and recredentialing independent practitioners. Applicable policies and procedures were compliant with NCQA standards and included all required provisions. On-site review of credentialing and recredentialing records revealed timely primary source verification of credentials, recredentialing, and exclusion searches using the NCQA-approved databases.

Provider agreement templates and practitioner credentialing and recredentialing applications contained all required information. Credentialing delegation subcontracts included all required provisions, and the BHO provided evidence of pre-delegation audits, ongoing monitoring and oversight, as well as annual audits (formal review).

Quality Assessment and Performance Improvement: ‘Ohana CCS was found to be compliant with 94 percent of the *Quality Assessment and Performance Improvement* standard. Hawaii-based staff members implemented ‘Ohana CCS’ quality improvement program (QIP) activities, with additional support, leadership, and consultation from its WellCare headquarters in Tampa. The ‘Ohana CCS QIP was supported by numerous policies, procedures, and plans that guided expectations for the care and service delivery system and also provided the framework through which monitoring and improvement activities were conducted.

‘Ohana CCS’ comprehensive quality improvement program description included its organizational structure, roles and responsibilities, governance, and committee and subcommittee structure. The scope of the quality program activities included all member demographic groups, care settings, and types of services, and the planned improvement activities were documented in an annual workplan with goals, metrics, identification of responsible individuals and committees, and time frames for reporting. The workplan was used as the basis for the BHO’s annual evaluation of the quality program.

‘Ohana CCS also provided its UM program description and relevant policies and procedures, which demonstrated the ongoing monitoring of its service utilization patterns and detection of over- and underutilization. Committee minutes and on-site interview discussions provided further evidence that CCS used these findings in its overall quality improvement program. For example, the BHO has established a community-based case management (CBCM) scorecard to incentivize the case management agencies contracted to manage the assessment, service and care planning, and monitoring of CCS members. The scorecard program included a financial withhold from the payment rate, to be awarded for achievement or improvement on five metrics based on quality and HEDIS measures.

Health Information Systems: ‘Ohana CCS was found to be compliant with 100 percent of the *Health Information Systems* standard. While the WellCare corporate office in Tampa maintained the core processing systems, network, and databases used by the BHO, ‘Ohana CCS also had access to Hawaii-based IS staff and data analysts to fulfill its business, regulatory, and ad hoc reporting needs and requirements, and to assist with trending data for its quality and utilization management programs.

‘Ohana CCS’ information system flow diagrams, policy and process documents, various reports, and staff members’ on-site interview responses provided evidence of the BHO’s ability to collect and report information on grievances and appeals, member and provider characteristics, services, utilization management data, and quality reporting metrics, among other data. Processes were in place to ensure data security and health information privacy.

‘Ohana CCS had corporate-level policies and plans related to disaster planning, disaster recovery, and business continuity which centered on data backup and redundancy in support of each local market. The BHO also provided a Hawaii-specific business impact analysis document and a business continuity plan

that demonstrated its local plan for readiness and assignment of responsibilities to maintain continuity during a loss, disruption, or interruption of critical business processes.

Practice Guidelines: ‘Ohana CCS was found to be compliant with 100 percent of the *Practice Guidelines* standard. ‘Ohana CCS’ process for practice guideline adoption was initiated through the WellCare corporate Medical Policy Committee, with a membership consisting of many WellCare medical directors from all markets and representing all specialties. The selected CPGs were then reviewed by the Hawaii UMAC, and finally approved through the QIC.

‘Ohana CCS had several CPGs for behavioral health disorders, including Attention Deficit Hyperactivity Disorder (ADHD); Major Depressive Disorder in Adults; and Screening, Brief Intervention, and Referral to Treatment (SBIRT) CPGs. Links to the CPGs were available to providers on the BHO’s website through the provider portal, and reminders about the location of the online CPGs and other provider resources were published in provider newsletters regularly. Additional comprehensive practice guideline information was contained in various provider “tool kits” that were given as resources to providers, and that provided technical assistance with coding of services and medical record documentation for certain conditions, as well as education about the HEDIS measure requirements for the conditions, if applicable.

To ensure that actual practice was consistent with the CPGs, quality of care cases was reviewed against the desired practice in the applicable guideline. In addition, CCS ensured the CPGs were reviewed and updated at least every two years.

Areas for Improvement

Below is a discussion of the areas for improvement, by standard, that were identified during the compliance review, and subject to implementation of a CAP.

Credentialing: ‘Ohana CCS Credentialing and Recredentialing procedure stated that notification of practitioner rights is included in the application/re-application cover letter and in the provider manual. However, during the on-site record review, there were no application cover letters within the credentialing/recredentialing records reviewed, and staff members stated that cover letters were not used. Because initial credentialing applicants do not yet have access to the provider manual, this method is not sufficient for notification of applicants’ rights under the credentialing program. ***‘Ohana CCS must develop a mechanism to notify initial credentialing applicants about their rights to review information submitted to support their credentialing application, to correct erroneous information, and to receive the status of their credentialing or recredentialing application.***

On-site review of recredentialing files for organizational providers revealed that ‘Ohana CCS did not consistently obtain complete ownership and control documents at recredentialing. In some cases, the documents were missing from the file, and in other cases the documents were incomplete. ***‘Ohana CCS must comply with federal and contract requirements and its own process designed to obtain completed ownership and control documents from all providers at the time of recredentialing.***

'Ohana CCS' credentialing policies and procedures adequately addressed assessment of organizational providers and stated that it will accept a CMS or State review in lieu of its own on-site quality assessment (as allowed according to NCQA) if the facility provided evidence (e.g., a report or form) confirming that the review was performed and the facility met standards. The policy also stated that review of the criteria used by the State or CMS would be used to ensure the criteria are acceptable to meet all elements of 'Ohana CCS' initial assessment criteria. However, during the on-site record review, HSAG found that 'Ohana CCS had not followed the processes described in its policy/procedure related to accepting State or CMS reviews in lieu of its own on-site quality assessment. ***'Ohana CCS must develop a mechanism to ensure State or CMS surveys meet its own criteria for on-site quality assessment if accepting such a survey in lieu of its own on-site visit for organizational providers who are not accredited.*** If 'Ohana CCS chooses to accept a CMS or State survey, it must ensure that the survey meets 'Ohana CCS' standards for on-site quality assessment. This can be accomplished as described in the BHO's policy, or 'Ohana CCS may establish a threshold for the survey that it will accept for participation in the network (for example, a percentage score or maximum number of deficiencies allowed). If 'Ohana CCS chooses a mechanism other than that currently described in the policy, the policy must be revised to reflect the process used.

Quality Assessment and Performance Improvement: To fulfill the requirement for a 'Ohana CCS quality assurance/utilization review (QA/UR) coordinator, the BHO provided the resume of a registered nurse (RN) with a behavioral health background who functioned as an on-site inpatient care manager within the clinical care section of 'Ohana's health services division. This position did not include a specific, active role in coordinating 'Ohana CCS' QA/UR program, required by the MQD's contract with the BHO to be at least a .5 full-time equivalent (FTE) position. ***'Ohana CCS must provide for a QA/UR coordinator position, and the position must be occupied by an RN licensed in the State of Hawaii who functions in the coordinator position for at least .5 FTE.***

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated 'Ohana CCS' IS capabilities for accurate HEDIS reporting. (Note: The call center standards [IS 6.0] were not applicable to the measures HSAG validated.) 'Ohana CCS was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that 'Ohana CCS had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. 'Ohana CCS elected to use three standard and 11 nonstandard supplemental data sources for its performance measure reporting. During the validation process of these supplemental data sources, errors were discovered within one of the nonstandard data sources. 'Ohana CCS removed the errors, and the data sources were approved for HEDIS 2016 measure reporting Additionally, during the onsite visit and preliminary rate review, the auditor found several issues during primary source verification of 'Ohana CCS' behavioral health assessment (BHA) tracker. 'Ohana CCS addressed the errors, and the data source was approved. All convenience samples passed HSAG's review.

Based on ‘Ohana CCS’ data systems and processes, the auditors made three recommendations:

- While errors identified during primary source verification of the non-standard data sources were resolved during validation, it was identified that there was concern with how data were captured in the database as compared to the source. HSAG recommended ‘Ohana CCS increase oversight of its non-standard supplemental data process and ensure that it follows the *HEDIS 2017, Volume 2: Technical Specifications for Health Plans*.
- HSAG recommended that only data sources relevant to the measures as part of the audit scope be included in the Roadmap.
- Based on issues identified during primary source verification, HSAG recommended that procedures to track and validate data related to the BHA measure be improved.

All QI measures which ‘Ohana CCS was required to report received the audit result of *Reportable*, where a reportable rate was submitted for the measure. Four measures received an *NA* designation due to small denominators—i.e., *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence* (two rates) and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (two rates). ‘Ohana CCS experienced no enrollment complications related to properly identifying these members on the daily and monthly enrollment files. Eligibility was properly identified within the BHO’s enrollment system. ‘Ohana CCS passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Controlling High Blood Pressure*
- Group B: Anticipatory Guidance & Counseling—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition*
- Group C: Laboratory—*Comprehensive Diabetes Care— HbA1c Control (<8.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 3*
- Group F: Exclusions—All Medical Record Exclusions

Access to Care Performance Measure Results

‘Ohana CCS’ Access to Care performance measure results are shown in Table 3-72. Both measure rates met or exceeded the 50th percentile but were below 75th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2017.

Table 3-72—UHC CP's HEDIS Results for QI Measures Under Access to Care

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment	—	39.47%	—	★★★
Engagement of AOD Treatment	—	11.26%	—	★★★

2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:
1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Behavioral Health Performance Measure Results

'Ohana CCS' Behavioral Health performance measure results are shown in Table 3-73. Three measure rates were at or above the 75th percentile but below the 90th percentile, and two measure rates were below the 25th percentile. There are two measure rates in this domain with an MQD Quality Strategy target for HEDIS 2017 (i.e., *Follow-Up After Hospitalization for Mental Illness—30-day Follow-Up* and *7-Day Follow-Up*), and 'Ohana CCS met or exceeded the established target for both rates, the 75th percentile.

Table 3-73—'Ohana CCS' HEDIS Results for QI Measures Under Behavioral Health

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	—	66.53%	—	★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	—	41.00%	—	★
Effective Continuation Phase Treatment	—	30.09%	—	★

	HEDIS 2016 Rate	HEDIS 2017Rate	Percentage Point Change	2017 Performance Level
Behavioral Health Assessment				
BHA Completion Within 30 Days of Enrollment (Within Standard)	—	29.86%	—	—
BHA Completion Within 31-60 Days of Enrollment (Not Within Standard)	—	21.30%	—	—
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence				
30 Days—13–17 Years	—	NA	—	—
30 Days—18+ Years	—	21.52%	—	—
30 Days—Total	—	21.52%	—	—
7 Days—13–17 Years	—	NA	—	—
7 Days—18+ Years	—	14.24%	—	—
7 Days—Total	—	14.24%	—	—
Follow-Up After Emergency Department Visit for Mental Illness				
30-Day Follow-Up	—	71.70%	—	—
7-Day Follow-Up	—	54.34%	—	—
Follow-Up After Hospitalization for Mental Illness				
30-Day Follow-Up	—	77.89%	—	★★★★
7-Day Follow-Up	—	60.95%	—	★★★★

*** Non-HEDIS state-defined measure; rates were reported using an MS Excel reporting template.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.
A "NA" value indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30 cases) to report a valid rate, resulting a small denominator (NA) audit designation. It is also used to indicate when star ratings are not applicable.
A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.
2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.
3- Differences are not reported if the 2016 rate is not reported.
4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Utilization and Health Plan Descriptive Information Performance Measure Results

Ohana CCS' Utilization and Health Plan Descriptive Information performance measure results are shown in Table 3-74. Utilization of more or fewer services is not indicative of performance; therefore, it is inappropriate to compare these rates to national Medicaid benchmarks.

Table 3-74—Ohana CCS' HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

	HEDIS 2016 Rate	HEDIS 2017 Rate	Change in Rate	2017 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	—	113.04	—	★
Outpatient Visits—Total	—	796.99	—	—
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	—	0.32%	—	—
20–44 Years Subtotal Percentage—Total	—	31.16%	—	—
45–64 Years Subtotal Percentage—Total	—	58.34%	—	—
65+ Years Subtotal Percentage—Total	—	10.18%	—	—
Mental Health Utilization				
Any Service—Total	—	93.80%	—	—
Inpatient—Total	—	8.38%	—	—
Intensive Outpatient or Partial Hospitalization—Total	—	2.56%	—	—
Outpatient, ED, or Telehealth—Total	—	93.25%	—	—

** For this indicator, a lower rate indicates better performance.*
**** Measure was not available for Medicaid IDSS reporting; rates were reported using an MS Excel reporting template.*
2017 performance levels represent the following national Medicaid percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating. See the list below for situations resulting in a "—" designation:

1- Numerators and denominators are not presented for weighted averages.

2- Results for 2016 are not presented for measures that were not reported, if the measure was new to HEDIS 2017, or if the State did not require the health plan to report it.

3- Differences are not reported if the 2016 rate is not reported.

4- Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate.

Conclusions and Recommendations

Based on HSAG's analyses of those 'Ohana CCS' measure rates with comparable benchmarks, about 38 percent of 'Ohana CCS' measure rates (three of eight rates) were at or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile in 2017. An additional two measure rates were at or above the 50th percentile but less than the 75th percentile, indicating moderate performance related to the Access to Care domain. Two measure rates ranked below the national Medicaid 25th percentile in 2017, suggesting an opportunity for improvement on the *Antidepressant Medication Management* and *Ambulatory Care—Total ED Visits (per 1,000 Member Months)* measures. HSAG recommends that 'Ohana CCS QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Behavioral Health
  - *Antidepressant Medication Management* (two rates)
- Utilization and Health Plan Descriptive Information
  - *Ambulatory Care—Total (per 1,000 Member Months)*

Validation of Performance Improvement Projects

For validation year 2017, 'Ohana CCS submitted two State-mandated PIP topics for validation: *Follow-Up After Hospitalization (FUH) for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*. The *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP topic addressed CMS' requirements related to quality outcomes—specifically, timeliness of, and access to care and services. The focus of the PIP was to increase the rate of members 18 years of age and older who are assigned to the Community Case Management agencies who were discharged from an inpatient psychiatric facility and who had a follow-up appointment with a mental health provider within seven days of discharge. The *Initiation of Alcohol and Substance Abuse Treatment* PIP topic addressed CMS' requirements related to quality outcomes—specifically, timeliness of, and access to care and services. The focus of the PIP was to increase the percentage of members 18 years of age and older who were assigned to the Community Case Management agencies, Care Hawaii Inc., or North Shore Mental Health; were discharged from an inpatient psychiatric facility; had an admitting diagnosis of alcohol or other drug dependence; and engaged in two alcohol and other drug treatments (AODs) within 30 days of treatment initiation. These PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

Findings

HSAG organized and analyzed 'Ohana CCS' PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal.

For each PIP, 'Ohana CCS was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. 'Ohana CCS developed a SMART Aim statement that quantified the improvement sought for each PIP.

HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence, Confidence,* and *Low Confidence*. Table 3-75 outlines the PIP topics, final reported SMART Aim statements, and the overall validation findings for the two PIPs.

Table 3-75—PIP Topic, SMART Aim Statements, and Confidence Levels for 'Ohana CCS

PIP Topic	SMART Aim Statement	Confidence Level
Follow-Up After Hospitalization (FUH) for Mental Illness	By December 31, 2016, increase the follow-up after discharge rate for mental illness within seven days for members ages 18 and older who are enrolled with community Based case management agency, Care Hawaii, Inc. from 22.0% to 43.0%	*Low Confidence*
Initiation of Alcohol and Substance Abuse Treatment	By December 31, 2016, increase the number of members ages 18 and older who are enrolled with community Based case management agency, Care Hawaii, Inc., or North Shore Mental Health, Inc., who were discharged from an inpatient psychiatric facility for alcohol or substance abuse treatment and engage in two AOD treatments within 30 days of initiation treatment from 6.0% to 38.0%	*Low Confidence*

HSAG assigned the level of *Low Confidence* to 'Ohana CCS' *Follow-Up After Hospitalization (FUH) for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment* PIPs. Although the SMART Aim goal was achieved for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

Follow-Up After Hospitalization (FUH) for Mental Illness PIP

'Ohana CCS' focus for the PIP was to increase the rate of members 18 years of age and older who were assigned to the community-based case management (CBCM) agency, were discharged from an inpatient psychiatric facility, and had a follow-up appointment with a mental health provider within seven days of discharge. The health plan achieved the SMART Aim for this PIP, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement. Therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP leading to the assigned confidence level are described below.

The health plan's rationale for selecting Care Hawaii, Inc., as the targeted CBCM agency for the PIP and the PIP's initial key driver diagram illustrating the content theory behind the PIP were described in Module 1. The health plan documented the SMART Aim measure definition and data collection

methodology in Module 2. After conducting a process mapping and failure modes and effects analysis (FMEA), 'Ohana CCS implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP are presented in Table 3-76.

Table 3-76—'Ohana CCS' Intervention Testing for *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Behavioral health (BH) case manager engaging with members while in-patient	Lack of communication with members	Follow-up appointments are not scheduled upon discharge from the hospital.	The health plan chose to **abandon** this intervention.
Effectiveness of weekend post hospital discharge notifications	Member engagement	Lack of a timely weekend discharge notification process to the community-based case management (CBCM) agencies.	The health plan chose to **abandon** this intervention.

HSAG validated 'Ohana CCS' *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP SMART Aim measure rates based on the SMART Aim run chart in Module 5. Table 3-77 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 3-77—'Ohana CCS' SMART Aim Measure Results for *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
Follow-up after discharge rate for mental illness within seven days and enrolled with Care Hawaii, Inc.	22.0%	43.0%	84.6%	*Low Confidence*

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART aim goal rates as 22.0 percent and 43.0 percent, respectively. Because the highest seven-day follow-up rate, which was achieved in March 2016, was above the desired follow-up rate, HSAG determined that the SMART Aim goal was achieved. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP a level of *Low Confidence*. Even though the SMART Aim goal was achieved, none of the implemented interventions could be clearly linked to the demonstrated improvement.

Initiation of Alcohol and Substance Abuse Treatment PIP

'Ohana CCS' focus for the PIP was to increase the percentage of members 18 years of age and older who were assigned to the community-based case management agencies, Care Hawaii, Inc., or North Shore Mental Health; were discharged from an inpatient psychiatric facility; had an admitting diagnosis of alcohol or other drug dependence; and engaged in two alcohol and other drug treatments (AODs) within 30 days of treatment initiation.

The health plan's rationale for selecting a CBCM agency (Care Hawaii, Inc., or North Shore Mental Health) as the targeted facility for the PIP, and the PIP's initial key driver diagram illustrating the content theory behind the PIP, were described in Module 1. The health plan documented the SMART Aim measure definition and data collection methodology in Module 2. After conducting a process mapping and FMEA, 'Ohana CCS implemented two interventions as part of this rapid-cycle PIP. The details of the improvement processes used and the interventions tested for the *Initiation of Alcohol and Substance Abuse Treatment* PIP are presented in Table 3-78.

Table 3-78—'Ohana CCS 's Intervention Testing for *Diabetes Care* PIP

Interventions	Key Drivers Addressed	Failure Modes Addressed	Conclusions
BH case manager engaging with members while inpatient	Lack of communication with members	AOD treatment was not scheduled prior to discharge from the hospital.	The health plan chose to **abandon** this intervention.
Timely hospital discharge appointment follow-up notifications	Member engagement	Lack of timely hospital discharge appointment follow-up notifications.	The health plan chose to **abandon** this intervention.

HSAG validated 'Ohana CCS' *Initiation of Alcohol and Substance Abuse Treatment* PIP SMART Aim measure rates based on the SMART Aim run chart in Module 5. Table 3-79 below provides a summary of the SMART Aim measure results reported by the health plan and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 3-79—'Ohana CCS' SMART Aim Measure Results for *Diabetes Care* PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Percentage of members who engaged in two AOD treatments within 30 days of inpatient initiation treatment	6.0%	38.0%	60.0%*	*Low Confidence*

* On the SMART Aim run chart in Module 5, the health plan plotted a rate of 100 percent for July 2015. This appears to be an outlier. Since the health plan had not implemented any interventions before July 2015, this rate was not counted toward this PIP's performance.

On the final SMART Aim measure run chart, the health plan plotted the baseline and SMART aim goal rates as 6.0 percent and 38.0 percent, respectively. Because the highest SMART Aim measure rate (60 percent) achieved in April 2016 exceeded the desired rate, HSAG determined that the SMART Aim goal was achieved. After a comprehensive review and evaluation of the health plan's PIP documentation, HSAG assigned the *Initiation of Alcohol and Substance Abuse Treatment* PIP a level of *Low Confidence*. Even though the SMART Aim goal was achieved, none of the implemented interventions could be clearly linked to the demonstrated improvement.

Strengths and Weaknesses

The validation findings suggest that even though 'Ohana CCS met the SMART Aim goal for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. Additionally, it appears that the interventions could not be executed as planned. The health plan noted that many members could not be outreached by the project team due to barriers related to staffing resources. Therefore, HSAG assigned a level of *Low Confidence* to both PIPs.

Areas for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the improvement strategies used must be methodologically sound and based on solid improvement science. 'Ohana CCS' PIP performance suggested several areas of opportunity that applied across the various PIP topics. HSAG recommended the following for 'Ohana CCS:

- Prepare provider partners or vendors regarding the resources, required logistics, and processes to successfully test an intervention.
- Ensure that the interventions are started in a timely manner. If delays occur, the health plan may not have incurred enough data points by the SMART Aim end date.
- Provide weekly or monthly data points showing the data and progress of intervention evaluation over time.
- Ensure that the core PIP team includes analytical staff members who are involved in all data-related processes of the PIP.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about 'Ohana CCS' performance in providing quality, accessible, and timely healthcare and services to its members.

Conclusions

In general, 'Ohana CCS' performance results illustrate moderate performance across the three EQR activities. While the compliance monitoring review activity revealed that 'Ohana CCS has established an operational foundation to support the quality, access, and timeliness of care and service delivery.

Performance on outcome and process measures shows moderate performance and some room for improvement.

'Ohana CCS' compliance review showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. The health plan demonstrated high compliance (i.e., 96 percent) with federal and State contract requirements for structure and operations. 'Ohana CCS also demonstrated a commitment to quality process improvement by closing all of its CAPs from the previous year's compliance review.

Overall, three (38 percent) of 'Ohana CCS' measure rates fell below the NCQA national Medicaid 25th percentile; the remaining measures that could be compared to national benchmarks were at or above the 50th percentile. Three measure rates in the Behavioral Health domain (i.e., *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* and *Follow-up After Hospitalization for Mental Illness* [two rates]) were at or above the 75th percentile but below the 90th percentile. 'Ohana CCS met or exceeded the MQD Quality Strategy target for the one measure evaluated for this population.

The results of 'Ohana CCS' PIPs indicated a need for ongoing quality improvement training of staff. HSAG assessed 'Ohana CCS' *Follow-Up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment* PIPs both as *Low Confidence.* While the validation findings determined that 'Ohana CCS met the SMART Aim goals for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. These results suggest that 'Ohana CCS continues to have opportunities for improvement in executing the rapid-cycle PIP process. HSAG recommends ongoing QI training specific to the rapid-cycle PIP process to improve results of State-mandated PIPs.

HSAG HEALTH SERVICES ADVISORY GROUP

4. Comparative Analysis of Health Plan Performance

Introduction

This section compares the EQR activity results across the Hawaii health plans and provides comparisons to statewide scores and/or national benchmarks, as appropriate.

Compliance Monitoring Review

Table 4-1 summarizes the results from the 2017 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plans scores with red shading indicate performance below the statewide score.

Table 4-1—Compliance Standards and Scores

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

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

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. Three of the standards were found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—*Provider Selection*, *Health Information Systems*, and *Practice Guidelines*. The *Subcontracts and Delegation* and *Credentialing* standards were identified as having the greatest opportunity for improvement, with statewide compliance scores of 92 percent and 93 percent, respectively. However, while the *Subcontracts and Delegation* standard exhibited the lowest overall performance (92 percent), this statewide compliance score was largely driven by KFHP QI's low score (56 percent); the remaining health plans scored 94 percent

(AlohaCare QI) and 100 percent (HMSA QI, ‘Ohana QI, UHC CP QI, and ‘Ohana CCS). Conversely, lower performance on the *Credentialing* standard was consistent across all health plans, with individual health plan scores ranging from 88 percent (KFHP QI) to 95 percent (HMSA QI).

Total compliance scores were at or above 95 percent for all health plans except for KFHP QI (88 percent). These results suggest an overall high degree of compliance with State and federal managed care requirements. Following the 2017 compliance monitoring reviews, each health plan received a detailed written report of findings and recommendations and was required to develop and implement a corrective action plan (CAP) for all items that were not scored *Met*. The MQD and HSAG reviewed and approved the health plans’ CAPs and will continue to provide follow-up monitoring until all identified deficiencies are corrected.

AlohaCare QI, HMSA QI, ‘Ohana QI, UHC CP QI, and ‘Ohana CCS had the highest overall compliance scores this year and, therefore, the fewest number of standard areas requiring CAPs. Although AlohaCare QI (96 percent), HMSA QI (97 percent), ‘Ohana QI (96 percent), UHC CP QI (95 percent), and ‘Ohana CCS (96 percent) demonstrated strong performance, opportunities for improvement requiring corrective actions were noted primarily within the *Credentialing* standard. KFHP QI was the lowest-scoring plan overall (88 percent) as a result of low compliance scores in *Subcontracts and Delegation* (56 percent) and *Credentialing* (88 percent). For all the health plans, the *Credentialing* standard represented the greatest and most consistent opportunity for improvement.

Validation of Performance Measures—HEDIS Compliance Audits

NCQA HEDIS Compliance Audits

Table 4-2 compares each QI health plan’s compliance with each information system (IS) standard reviewed during the 2017 NCQA HEDIS Compliance Audit. As demonstrated below, all QI health plans were *Fully Compliant* with the IS standards applicable to the measures under the scope of the audit except for AlohaCare QI (IS 5.0 = *Partially Compliant*). Overall, the health plans followed the NCQA HEDIS 2016 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of *Reportable* except for two measures reported by UHC CP QI that received a *Biased Rate* designation: *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence*. Of note, the QI health plans were not required to report any HEDIS call center measures; therefore, IS 6.0 was *Not Applicable* and not included under the scope of the Hawaii Medicaid audit.

Table 4-2—Validation of Performance Measures Comparison: NCQA HEDIS Compliance Audit Information System Review Results

QI Health Plan	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 QI	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Partially Compliant*	*Not Applicable*	*Fully Compliant*
HMSA QI	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*
KFHP QI	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*
‘Ohana QI	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*
UHC CP QI	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Not Applicable*	*Fully Compliant*

HEDIS Performance Measure Results

This section of the report highlights health plans’ performance for the current year by domain of care. Each table illustrates the health plans’ 2017 measure rates and their performance relative to the NCQA national Medicaid HEDIS 2016 percentiles, where applicable.[4-1] The performance level star ratings are defined as follows:

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

[4-1] 2017 performance measure rates were compared to HEDIS Audit Means and Percentiles for HEDIS 2016 for benchmarking purposes.

Access to Care

Table 4-3 displays the Access to Care measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-3—Comparison of 2017 Access to Care Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Adults' Access to Preventive/Ambulatory Health Services					
Ages 20 to 44 Years	62.04% ★	71.43% ★	77.10% ★★	60.74% ★	58.08% ★
Ages 45 to 64 Years	74.27% ★	82.37% ★	85.34% ★★	80.42% ★	79.37% ★
Ages 65 Years and Older	81.52% ★★	87.07% ★★	95.07% ★★★★★	90.40% ★★★	94.46% ★★★★★
Total	66.97% ★	75.68% ★	80.83% ★★	74.57% ★	76.01% ★
Children and Adolescents' Access to Primary Care Practitioners					
Ages 12 to 24 Months	94.23% ★★	97.50% ★★★★	98.40% ★★★★★	89.95% ★	91.55% ★
Ages 25 Months to 6 Years	81.98% ★	89.48% ★★★	93.77% ★★★★★	72.32% ★	74.73% ★
Ages 7 to 11 Years	85.86% ★	92.12% ★★★	92.49% ★★★	80.26% ★	82.46% ★
Ages 12 to 19 Years	83.68% ★	90.13% ★★★	91.78% ★★★	79.79% ★	79.34% ★
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					
Initiation of Alcohol or Other Drug Treatment	34.41% ★★	38.10% ★★★	41.72% ★★★	35.88% ★★★	42.62% ★★★
Engagement of Alcohol or Other Drug Treatment	9.24% ★★	16.38% ★★★★	14.69% ★★★★	10.79% ★★	10.36% ★★★

Within the Access to Care performance measure domain, KFHP QI performed best among the health plans, with four measure rates ranking at or above the 75th percentile, of which three were at or above the 90th percentile. HMSA QI followed KFHP QI's performance closely with two measures ranking at or above the 75th percentile, but below the 90th percentile. AlohaCare QI demonstrated the lowest performance among the health plans, with all measure rates ranking below the national Medicaid 50th percentile, and six measure rates being below the 25th percentile. *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* was the highest-performing measure across the health plans. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2017.

Children's Preventive Health

Table 4-4 displays the Children's Preventive Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-4—Comparison of 2017 Children's Preventive Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Adolescent Well-Care Visits					
Adolescent Well-Care Visits	38.93% ★	46.96% ★★	44.52% ★★	29.68% ★	36.98% ★
Childhood Immunization Status					
Combination 3	61.31% ★	53.77% ★	79.71% ★★★★	46.95% ★	55.65% ★
Hepatitis B	82.97% ★	70.80% ★	93.24% ★★★★	62.33% ★	76.86% ★
HiB	82.48% ★	83.21% ★	90.38% ★★★	66.31% ★	77.41% ★
IPV	82.24% ★	78.59% ★	94.02% ★★★★★	63.93% ★	76.58% ★
MMR	82.48% ★	85.16% ★	92.72% ★★★★	68.70% ★	76.58% ★
Pneumococcal Conjugate	66.18% ★	64.23% ★	82.18% ★★★	50.13% ★	60.33% ★
VZV	81.51% ★	85.40% ★	91.81% ★★★	67.64% ★	74.66% ★
Immunizations for Adolescents					
Combination 1	50.36% ★	50.12% ★	82.66% ★★★★	40.97% ★	34.38% ★
Combination 2	14.11% —	18.25% —	32.45% —	11.45% —	4.69% —
HPV	16.55% —	20.19% —	33.57% —	13.22% —	5.73% —
Meningococcal	53.04% ★	54.26% ★	85.03% ★★★★	45.81% ★	37.50% ★
Tdap	57.66% ★	56.20% ★	84.48% ★★	45.37% ★	40.10% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Well-Child Visits in the First 15 Months of Life					
*No Well-Child Visits**	2.19% ★★	1.67% ★★★	0.14% ★★★★★	3.87% ★	4.11% ★
Six or More Well-Child Visits	67.88% ★★★★	74.72% ★★★★★	75.04% ★★★★★	53.04% ★	61.88% ★★★
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	65.69% ★★	73.17% ★★★	83.34% ★★★★★	57.57% ★	61.07% ★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	80.78% ★★★★	76.16% ★★★	94.03% ★★★★★	85.40% ★★★★	79.32% ★★★★
Counseling for Nutrition—Total	65.21% ★★★	62.29% ★★	98.51% ★★★★★	61.80% ★★	65.21% ★★★
Counseling for Physical Activity—Total	60.34% ★★★	40.88% ★	97.01% ★★★★★	52.55% ★★	58.64% ★★★

* For this indicator, a lower rate indicates better performance.
A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating.
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Within the Children's Preventive Health performance measure domain, KFHP QI performed best among the health plans, with 12 measure rates ranking at or above the 75th percentile, of which seven were at or above the 90th percentile. 'Ohana QI demonstrated the lowest performance among the health plans, with all but one measure rate (*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total)* ranking below the national Medicaid 50th percentile, and 14 measure rates being below the 25th percentile. The *Childhood Immunization Status* and *Immunizations for Adolescents* measure rates were the lowest across the health plans, while the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Well-Child Visits in the First 15 Months of Life* measure rates had the highest comparative performance.

Only one measure (*Childhood Immunization Status—Combination 3)* within the Children's Preventive Health domain was associated with an MQD Quality Strategy target in 2017. Of the health plans, only KFHP QI met or exceeded the target.

Women's Health

Table 4-5 displays the Women's Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-5—Comparison of 2017 Women's Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Breast Cancer Screening					
Breast Cancer Screening	49.71% ★	64.90% ★★★	75.87% ★★★★★	52.71% ★★	62.02% ★★★
Cervical Cancer Screening					
Cervical Cancer Screening	53.77% ★★	64.63% ★★★★	76.80% ★★★★★	44.04% ★	43.80% ★
Chlamydia Screening in Women					
16–20 Years	41.83% ★	56.49% ★★★	65.36% ★★★★	46.97% ★★	50.31% ★★
21–24 Years	43.02% ★	58.81% ★★	71.43% ★★★★	56.15% ★★	55.90% ★★
Total	42.42% ★	57.55% ★★★	67.84% ★★★★	53.06% ★★	54.26% ★★
Frequency of Ongoing Prenatal Care					
*<21 Percent of Expected Visits**	21.41% ★	20.19% ★	0.78% ★★★★★	14.60% ★★	14.66% ★★
≥81 Percent of Expected Visits	37.23% ★	29.20% ★	82.55% ★★★★★	44.04% ★	47.64% ★★
Prenatal and Postpartum Care					
Postpartum Care	55.72% ★★	50.61% ★	80.99% ★★★★★	46.47% ★	54.97% ★
Timeliness of Prenatal Care	72.75% ★	71.05% ★	93.23% ★★★★★	76.40% ★★	78.80% ★★

* For this indicator, a lower rate indicates better performance.
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target

Within the Women's Health performance measure domain, KFHP QI performed best among the health plans, with nine measure rates at or above the 75th percentile, of which six were at or above the 90th percentile. HMSA QI exhibited moderate performance with nearly half of its measure rates being at or above the 50th percentile. AlohaCare QI demonstrated the lowest performance among the health plans, with all measure rates ranking below the national Medicaid 50th percentile and seven measure rates being below the 25th percentile. Both 'Ohana QI and UHC CP QI also showed low performance across all measures. The *Frequency of Ongoing Prenatal Care* and *Prenatal and Postpartum Care* measure rates scored consistently low across all health plans except for KFHP QI.

There were four measures[4-2] within the Women's Health domain associated with an MQD Quality Strategy target in 2017. Of the health plans, KFHP QI met or exceeded all targets and HMSA QI met or exceeded one of the targets.

Care for Chronic Conditions

Table 4-6 displays the Care for Chronic Conditions measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-6—Comparison of 2017 Care for Chronic Conditions Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Annual Monitoring for Patients on Persistent Medications					
Annual Monitoring for Members on ACE Inhibitors or ARBs	85.71% ★★	85.48% ★	93.67% ★★★★★	91.61% ★★★★	91.80% ★★★★
Annual Monitoring for Members on Digoxin	56.41% ★★★	46.58% ★	96.67% ★★★★★	46.07% ★	51.69% ★★
Annual Monitoring for Members on Diuretics	85.90% ★★	84.66% ★	93.41% ★★★★★	91.86% ★★★★	91.88% ★★★★
Total	85.47% ★★	84.88% ★	93.64% ★★★★★	90.97% ★★★★	91.18% ★★★★
Comprehensive Diabetes Care					
Blood Pressure Control (<140/90 mm Hg)	52.01% ★	50.91% ★	81.30% ★★★★★	60.61% ★★★	65.20% ★★★
Eye Exam (Retinal) Performed	50.73% ★★	62.04% ★★★★	68.08% ★★★★	60.39% ★★★	69.60% ★★★★★
HbA1c Control (<7.0%)	22.37% ★	32.11% ★★	33.90% ★★★	33.00% ★★	32.75% ★★
HbA1c Control (<8.0%)	40.69% ★★	42.88% ★★	58.37% ★★★★	45.93% ★★	50.72% ★★★
*HbA1c Poor Control (>9.0%)**	52.19% ★★	47.63% ★★	30.13% ★★★★	45.64% ★★	38.48% ★★★
Hemoglobin A1c (HbA1c) Testing	78.83% ★	85.04% ★★	95.48% ★★★★★	85.32% ★★	86.64% ★★★
Medical Attention for Nephropathy	84.49% ★	88.50% ★★	95.08% ★★★★★	89.53% ★★	91.36% ★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	48.18% ★★	42.82% ★	77.92% ★★★★★	55.58% ★★★	61.98% ★★★

[4-2] The MQD Quality Strategy targets were established for four measures within the Women's Health domain: *Breast Cancer Screening, Cervical Cancer Screening, Frequency of Ongoing Prenatal Visits,* and *Timeliness of Prenatal Care*.

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Medication Management for People with Asthma					
Medication Compliance 50%—Total	57.00% ★★★	54.73% ★★	42.02% ★	65.70% ★★★★	63.45% ★★★★
Medication Compliance 75%—Total	35.10% ★★★	31.62% ★★★	18.59% ★	43.80% ★★★★	40.61% ★★★★

* For this indicator, a lower rate indicates better performance.
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Within the Care for Chronic Conditions performance measure domain, KFHP QI performed best among the health plans, with 11 measure rates ranking at or above the 75th percentile, of which seven were at or above the 90th percentile. UHC CP QI's and 'Ohana QI's performance was similar, with six measure rates and 5 measure rates, respectively, ranking at or above the 75th percentile, of which one measure rate for UHC CP QI was at or above the 90th percentile. AlohaCare QI and HMSA QI demonstrated the lowest performance among the health plans, with most measure rates ranking below the national Medicaid 50th percentile (11 measures and 12 measures, respectively). Both AlohaCare QI and HMSA QI showed low performance across all measures.

There were eight measures[4-3] within the Care of Chronic Conditions domain associated with an MQD Quality Strategy target in 2017. Of the health plans, KFHP QI met or exceeded six targets, UHC CP QI met or exceeded five targets, and HMSA QI and 'Ohana QI met or exceeded one and two targets, respectively. Only AlohaCare QI met none of the MQD Quality Strategy targets in 2017.

Behavioral Health

Table 4-7 displays the Behavioral Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-7—Comparison of 2017 Behavioral Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Antidepressant Medication Management					
Effective Acute Phase Treatment	50.28% ★★	48.50% ★★	44.75% ★	48.19% ★	52.38% ★★
Effective Continuation Phase Treatment	38.47% ★★★	32.51% ★	28.79% ★	35.32% ★★	39.38% ★★★
Cardiovascular Monitoring for People with Cardiovascular Disease Schizophrenia					
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NA	NA	NA	NA	NA

[4-3] Within this domain, there are eight MQD Quality Strategy targets: *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, and Blood Pressure Control (<140/90 mm Hg); Controlling High Blood Pressure*; and *Medication Management for People with Asthma* (two rates).

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.85% ★	69.41% ★	73.33% ★	73.88% ★	78.22% ★★
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence					
30 Days—13–17 Years	16.22% —	25.00% —	NA	NA	NA
30 Days—18+ Years	25.73% —	41.16% —	33.33% —	14.86% —	33.40% —
30 Days—Total	25.09% —	39.90% —	32.05% —	14.58% —	33.47% —
7 Days—13–17 Years	13.51% —	21.05% —	NA	NA	NA
7 Days—18+ Years	17.60% —	32.55% —	23.61% —	8.25% —	28.07% —
7 Days—Total	17.33% —	31.65% —	23.08% —	8.10% —	28.02% —
Follow-Up After Emergency Department Visit for Mental Illness					
30-Day Follow-Up	45.84% —	58.29% —	73.05% —	43.22% —	72.10% —
7-Day Follow-Up	27.08% —	37.15% —	46.81% —	25.71% —	64.01% —
Follow-Up After Hospitalization for Mental Illness					
30-Day Follow-Up	45.22% ★	55.36% ★★	70.09% ★★★	61.17% ★★	72.68% ★★★★
7-Day Follow-Up	23.53% ★	36.54% ★★	53.27% ★★★	37.80% ★★	59.02% ★★★★
Follow-Up Care for Children Prescribed ADHD Medications					
Initiation Phase	45.65% ★★★	52.00% ★★★★	72.86% ★★★★★	NA	NA
Continuation and Maintenance Phase	NA	60.29% ★★★	NA	NA	NA
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness**					
*Follow-Up With Assigned PCP Following Hospitalization for Mental Illness***	11.36% —	15.46% —	8.33% —	28.10% —	6.70% —

** Non-HEDIS state-defined measure; rates were reported using an MS Excel reporting template.

A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating.

Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target

Within the Behavioral Health domain, performance among the health plans was moderate, with no health plan consistently outperforming the other plans. 'Ohana QI demonstrated the lowest performance among the health plans, with all measure rates ranking below the national Medicaid 50th percentile.

There was one measure[4-4] within the Behavioral Health domain associated with an MQD Quality Strategy target in 2017. Of the health plans, only UHC CP QI met or exceeded the MQD Quality Strategy targets in 2017.

Utilization and Health Plan Descriptive Information

Table 4-8 displays the Utilization and Health Plan Descriptive Information measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-8—Comparison of 2017 Utilization and Health Plan Descriptive Information Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Ambulatory Care—Total (per 1,000 Member Months)					
*ED Visits—Total**	49.18 ★★★★	42.51 ★★★★★	29.22 ★★★★★	64.65 ★★	61.01 ★★★
Outpatient Visits—Total	278.82 —	341.05 —	277.58 —	502.90 —	556.18 —
Enrollment by Product Line—Total					
0–19 Years Subtotal Percentage—Total	50.66% —	53.15% —	57.13% —	22.62% —	20.53% —
20–44 Years Subtotal Percentage—Total	31.04% —	29.38% —	25.89% —	33.32% —	32.47% —
45–64 Years Subtotal Percentage—Total	15.67% —	16.29% —	15.31% —	28.78% —	25.53% —
65+ Years Subtotal Percentage—Total	2.63% —	1.18% —	1.67% —	15.28% —	21.47% —
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence					
Maternity—Average Length of Stay—Total	2.63 —	2.55 —	2.84 —	2.65 —	2.48 —
Maternity—Days per 1,000 Member Months—Total	7.75 —	6.47 —	6.95 —	5.59 —	4.29 —
Maternity—Discharges per 1,000 Member Months—Total	2.95 —	2.53 —	2.44 —	2.11 —	1.73 —
Medicine—Average Length of Stay—Total	4.75 —	4.92 —	5.19 —	5.59 —	5.41 —
Medicine—Days per 1,000 Member Months—Total	15.30 —	11.15 —	10.09 —	51.29 —	27.62 —
Medicine—Discharges per 1,000 Member Months—Total	3.22 —	2.27 —	1.94 —	9.17 —	5.11 —
Surgery—Average Length of Stay—Total	8.56 —	6.85 —	6.87 —	12.06 —	10.57 —

[4-4] The MQD Quality Strategy target was established for one measure within the Behavioral Health domain: *Follow-Up After Hospitalization for Mental Illness* (two rates).

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Surgery—Days per 1,000 Member Months—Total	12.87 —	6.73 —	5.03 —	45.43 —	28.72 —
Surgery—Discharges per 1,000 Member Months—Total	1.50 —	0.98 —	0.73 —	3.77 —	2.72 —
Total Inpatient—Average Length of Stay—Total	4.95 —	4.47 —	4.59 —	6.97 —	6.60 —
Total Inpatient—Days per 1,000 Member Months—Total	33.58 —	22.35 —	19.75 —	100.73 —	59.20 —
Total Inpatient—Discharges per 1,000 Member Months—Total	6.79 —	5.00 —	4.30 —	14.45 —	8.97 —
Mental Health Utilization					
Any Service—Total	8.02% —	10.44% —	7.55% —	14.28% —	11.71% —
Inpatient—Total	0.43% —	0.33% —	0.36% —	1.03% —	0.58% —
Intensive Outpatient or Partial Hospitalization—Total	0.06% —	0.04% —	0.14% —	0.08% —	0.03% —
Outpatient, ED, or Telehealth—Total	7.84% —	10.35% —	7.50% —	13.93% —	11.49% —
Plan All-Cause Readmissions					
*Plan All-Cause Readmissions****	14.37% ★★★	11.15% ★★★★	10.49% ★★★★	16.95% ★★	10.71% ★★★★

* For this indicator, a lower rate indicates better performance.
*** Measure was not available for Medicaid IDSS reporting; rates were reported using an MS Excel reporting template. The Medicare benchmark was used for the comparison to national percentile scoring.
A "—" indicates that a result is not reported for a numerator, denominator, rate, rate difference, or star rating.
Yellow shading indicates the measure rate met or exceeded the MQD Quality Strategy target.

Within the Utilization and Health Plan Descriptive Information performance measure domain, the *Ambulatory Care—Emergency Department Visits per 1,000 Member Months* rate for KFHP QI and HMSA QI ranked at or above the national Medicaid 90th percentile, followed by AlohaCare QI (75th to 89th percentile) and UHC CP QI (50th to 74th percentile). Only 'Ohana QI's measure rate fell below the national Medicaid 50th percentile. Within this domain, *Ambulatory Care—Emergency Department Visits per 1,000 Member Months* is the only measure with an MQD Quality Strategy target established for HEDIS 2016. KFHP QI and HMSA QI met or exceeded the MQD Quality Strategy target for this measure.

The remaining reported rates for the Utilization and Health Plan Descriptive Information measures are presented for informational purposes only, as utilization of more or fewer outpatient services is not indicative of performance. Therefore, HSAG could not draw conclusions on performance based on the reported Utilization and Health Plan Descriptive Information results. Nonetheless, combined with other performance metrics, health plans' utilization results provide additional information that may be used to assess barriers or patterns of utilization when evaluating improvement interventions.

Summary of MQD Quality Strategy Targets

Table 4-9 summarizes health plan performance relative to the MQD Quality Strategy targets. Highlighted cells indicate whether health plan performance for a given measure rate met or exceeded the target threshold established by the MQD.

Table 4-9—Percentage of MQD Quality Strategy Targets Met or Exceeded for QI Population^

Measure	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI
Access to Care	—	—	—	—	—
Children’s Preventive Care					
Childhood Immunization Status—Combination 3 (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Women’s Health					
Breast Cancer Screening (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Cervical Cancer Screening (75th Percentile)	Not Met	Met	Met	Not Met	Not Met
Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Timeliness of Prenatal Care (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Care for Chronic Conditions					
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg) (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Comprehensive Diabetes Care—Eye Exam Performed (75th Percentile)	Not Met	Met	Met	Not Met	Met
Comprehensive Diabetes Care—HbA1c Control (<8.0%) (50th Percentile)	Not Met	Not Met	Met	Not Met	Met
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)** (50th Percentile)	Not Met	Not Met	Met	Not Met	Met
Comprehensive Diabetes Care—HbA1c Testing (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Controlling High Blood Pressure (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Medication Management for People with Asthma—Medication Compliance 50% (75th Percentile)	Not Met	Not Met	Not Met	Met	Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Medication Management for People with Asthma—Medication Compliance 75% (75th Percentile)	Not Met	Not Met	Not Met	Met	Met
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-up (75th Percentile)	Not Met	Not Met	Not Met	Not Met	Met
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-up (75th Percentile)	Not Met	Not Met	Not Met	Not Met	Met
Utilization and Health Plan Descriptive Information					
*Ambulatory Care—ED Visits per 1,000 Member Months** (90th Percentile)	Not Met	Met	Met	Not Met	Not Met
TOTAL MQD Targets Met	**0**	**3**	**12**	**2**	**7**
Percent MQD Targets Met	**0.0%**	**18.8%**	**75.0%**	**12.5%**	**43.8%**

^ Excludes HEDIS 2016 measures that did not have MQD Quality Strategy targets and does not include measures that were not comparable to targets (e.g., rates designated as NA).

* For this indicator, a lower rate indicates better performance.

A "—" indicates there were no MQD Quality Strategy targets established by the MQD for a specific domain.

All five health plans had reportable rates for the 16 measures with MQD Quality Strategy targets. KFHP QI met or exceeded three-quarters (75 percent) of the MQD Quality Strategy targets, followed by UHC CP QI, which met or exceeded the MQD Quality Strategy targets for seven measures (43.8 percent). HMSA QI and 'Ohana QI met or exceeded three and two of the MQD QS targets, respectively, while AlohaCare QI did not meet any of the targets. These results, in combination with overall HEDIS measure rates, suggest considerable room for improvement for AlohaCare QI, HMSA QI, and 'Ohana QI in meeting the goals outlined in the MQD Quality Strategy.

Validation of Performance Improvement Projects

Table 4-10 summarizes HSAG's key validation findings for the two PIPs conducted by the QUEST Integration health plans. The key validation findings include whether each PIP achieved its SMART Aim goal and the overall confidence level HSAG assigned to each PIP.

- The first finding, achieving the SMART Aim goal, represents the PIP outcomes and whether the PIP demonstrated meaningful improvement.
- The second finding, the confidence level, represents HSAG's overall validation findings based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels include *High Confidence*, *Confidence*, and *Low Confidence*, depending on the performance of the PIP. HSAG assigned a level of *High Confidence* to a PIP only if the SMART Aim goal was achieved and the improvement strategies were clearly linked to the demonstrated improvement. HSAG did not assign a confidence level to a PIP when the reported PIP results were not credible.

The details of the rapid-cycle PIP process and HSAG's scoring methodology are described in Appendix A.

Table 4-10—PIP Validation Findings for the QI Health Plans

Health Plan	Plan All-Cause Readmission		Diabetes Care	
	SMART Aim Goal	Confidence Level	SMART Aim Goal	Confidence Level
AlohaCare QI	*Not Achieved*	*Low Confidence*	*Achieved*	*High Confidence*
HMSA QI	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*
KFHP QI	*Achieved*	*Confidence*	*Achieved*	*Low Confidence*
'Ohana QI	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*
UHC CP QI	*Achieved*	*Low Confidence*	*Achieved*	*Confidence*
Percent Achieved/ High Confidence	**80%**	**0%**	**100%**	**20%**

Health plan performance on the two PIPs demonstrates the continued need for further skill development around the application and documentation of the rapid-cycle PIP process, especially in the area of intervention testing through Plan-Do-Study-Act (PDSA) cycles. Well-planned, appropriately executed, and clearly documented PDSA cycles are necessary to achieve a *High Confidence* level in a PIP and drive sustainable improvement.

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

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

Table 4-11 summarizes HSAG's key validation findings for the two PIPs conducted by 'Ohana CCS.

Table 4-11—PIP Validation Findings for 'Ohana CCS

	Follow-Up After Hospitalization for Mental Illness		Initiation of Alcohol and Substance Abuse Treatment	
Health Plan	SMART Aim Goal	Confidence Level	SMART Aim Goal	Confidence Level
'Ohana CCS	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*

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

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

Global Ratings—QI Health Plans

Table 4-12 presents the question summary rates and global proportions for each QI health plan and the QI Program aggregate.[4-5]

Table 4-12—Comparison of 2017 QUEST Integration Child CAHPS Results

	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	QI Program Aggregate
Global Ratings						
Rating of Health Plan	67.3%	73.6% ↑	73.9% ↑	60.4% ↓	66.3%	69.1%
Rating of All Health Care	62.5%	69.8% ↑	70.0% ↑	59.7%	60.2%	65.0%
Rating of Personal Doctor	73.9%	74.6%	80.0% ↑	68% ↓	70.5%	74.1%
Rating of Specialist Seen Most Often	67.3% +	72.6% +	72% +	73.2% +	75.9%	72.9%
Composite Measures						
Getting Needed Care	82.1%	87.0%	84.2%	77.6%	81.5%	82.8%
Getting Care Quickly	83.8%	91% ↑	90.5% ↑	81.5% ↓	81.6% ↓	86.4%
How Well Doctors Communicate	91.9%	95.4%	96.8% ↑	93.0%	93.5%	94.4%
Customer Service	89.8%	87.7%	92.5% ↑	80.3% ↓	85.2%	86.9%
Shared Decision Making	79.7% +	80.6% +	81.4%	85.8% +	85.8% +	82.7%
Individual Item Measures						
Coordination of Care	79.5% +	84.4%	89.9%	77.8%	85.0%	83.8%
Health Promotion and Education	73.4%	77.3%	76.1%	76.6%	75.0%	75.8%

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.
(+) indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
↑ 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.

[4-5] 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, KFHP QI, 'Ohana QI, and UHC CP QI scores to the 2016 NCQA national child Medicaid average revealed the following:

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

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

- AlohaCare QI did not score significantly higher or lower than the QI Program aggregate on any measures.
- HMSA QI scored significantly higher than the QI Program aggregate on three measures: *Rating of Health Plan, Rating of All Health Care,* and *Getting Care Quickly.*
- KFHP 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 Personal Doctor, Getting Care Quickly,* and *Customer Service*.
- UHC CP QI scored significantly lower than the QI Program aggregate on one measure, *Getting Care Quickly*.

Global Ratings—Child Health Insurance Program (CHIP)

Table 4-13 presents the question summary rates and global proportions for the Hawaii CHIP population.

Table 4-13—Comparison of 2017 CHIP CAHPS Results

	2016 CHIP
Global Ratings	
Rating of Health Plan	72.2%
Rating of All Health Care	69.1%
Rating of Personal Doctor	73.8%
Rating of Specialist Seen Most Often	72.1%
Composite Measures	
Getting Needed Care	82.3%
Getting Care Quickly	87.1%
How Well Doctors Communicate	95.5%
Customer Service	85.2%
Shared Decision Making	80.3%
Individual Item Measures	
Coordination of Care	82.5%
Health Promotion and Education	79.7%

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.

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

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

NCQA Comparisons—QI Health Plans[4-6]

Table 4-14 shows the QI Program aggregate's and each participating QI health plan's member satisfaction ratings and three-point mean scores for each of the four global ratings.

Table 4-14—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	★★★★	★★★★★	★★★★	★★★★ +
KFHP QI	★★★★★	★★★★★	★★★★★	★★★★ +
'Ohana QI	★	★	★	★★★★★ +
UHC CP QI	★★	★★★	★★★	★★★★★

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

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

Table 4-15 shows the QI Program aggregate's and each participating QI health plan's member satisfaction ratings and three-point mean scores for each of the four composite measures.

Table 4-15—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	★★★	★★	★★★★	★
KFHP QI	★★	★★	★★★★★	★★★★
'Ohana QI	★	★	★★★	★
UHC CP QI	★	★	★★★	★

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

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

Table 4-16 shows the QI Program aggregate's and each participating QI health plan's child member satisfaction ratings on the one individual item measure.

Table 4-16—NCQA Comparisons: Individual Measure

Plan Name	Coordination of Care
QI Program Aggregate	★★
AlohaCare QI	★
HMSA QI	★★
KFHP QI	★★★★
'Ohana QI	★
UHC CP QI	★★★

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

One of the goals the MQD identified for the Hawaii Medicaid program is to improve member satisfaction with health plan services. The MQD selected three CAHPS measures as part of its Quality Strategy to monitor the QI health plans' performance on members' satisfaction with these areas of service compared to national benchmarks. The three CAHPS Quality Strategy measures the MQD selected were *Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*.

HMSA QI's and KFHP QI's member satisfaction ratings for *Rating of Health Plan* and *How Well Doctors Communicate* met or exceeded the 75th percentile requirement. None of the QI health plans' member satisfaction ratings met or exceeded the 75th percentile for *Getting Needed Care*. AlohaCare QI's, 'Ohana QI's, and UHC CP QI's member satisfaction ratings did not meet or exceed the 75th percentile for any of the three CAHPS Quality Strategy measures.

NCQA Comparisons—CHIP[4-7,4-8]

Table 4-17 presents the overall member satisfaction ratings for the Hawaii CHIP population on each of the four global ratings.

Table 4-17—NCQA Comparisons: Global Ratings

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

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

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

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

Table 4-18 presents the overall member satisfaction ratings for the Hawaii CHIP population on each of the four composite measures.

Table 4-18—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

Table 4-19 presents the overall member satisfaction rating for the Hawaii CHIP population on the *Coordination of Care* individual item measure.

Table 4-19—NCQA Comparisons: Individual Item

Individual Item Measure	Coordination of Care
Hawaii CHIP	★

The NCQA comparisons revealed the following summary results:

- CHIP 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*.
- CHIP scored at or between the 75th and 89th percentiles on one measure: *How Well Doctors Communicate*.
- CHIP scored below the 25th percentile on four measures: *Getting Needed Care, Getting Care Quickly, Customer Service,* and *Coordination of Care*.

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5. Assessment of Follow-up to Prior Year Recommendations

Introduction

This section of the annual report presents an assessment of how effectively the QUEST Integration health plans addressed the improvement recommendations made by HSAG in the prior year (2016) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, and CAHPS. The provider survey was performed in 2016 and, therefore, is addressed in this section. The CCS program members were not separately sampled for the CAHPS survey as they were included in the QI health plans' sampling; therefore, there are not separate CAHPS results related to CCS members.

Except for the compliance monitoring section and PIPs, the improvements and corrective actions related to the EQR activity recommendations were self-reported by each health plan. HSAG reviewed this information to identify the degree to which the health plans' initiatives were responsive to the improvement opportunities.

Compliance Monitoring Review

Formal follow-up reevaluations of the health plans' corrective actions to address the deficiencies identified in the 2016 compliance reviews were carried over to 2017 and were completed in early 2017. The specific compliance review findings and recommendations were reported in the 2016 EQR Report of Results. As appropriate, HSAG conducted technical assistance for the plans and conducted the follow-up assessments of compliance either telephonically or on-site as indicated by the significance or number of deficiencies. All health plans were found to have sufficiently addressed and corrected their findings of deficiencies through implementation of corrective action plans and were found to be in full compliance with requirements during the reevaluations conducted by HSAG.

Performance Improvement Projects

In alignment with the rapid-cycle PIP process, recommendations are made at the submission of each PIP module. The health plans addressed the recommendations as part of either the resubmission of the module or the submission of the next module. Therefore, the 2016 technical report did not contain specific recommendations. All health plans worked with HSAG to implement recommended improvements to subsequent PIP submissions.

AlohaCare Quest Integration (AlohaCare QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2016 QI Population Recommendations

HSAG recommended that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
  - *Children and Adolescents' Access to Primary Care Practitioners*
  - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- Children's Preventive Care
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications*

QI Population Improvement Activities Implemented

Data systems and process: AlohaCare QI added additional supplemental data sources for HEDIS 2017 in the form of EMR feeds and data files from five Community Health Centers. AlohaCare QI's focus centered on implementing the data extracts, satisfying the requirements of the Roadmap, obtaining auditor approval, and the testing of these data sources. AlohaCare QI's objective was to gather as much data as resources allowed for the HEDIS 2017 season and evaluate the rate impact by each supplemental data

The benefit to AlohaCare QI data aggregation of data from its Community Health Center partners goes beyond the impact on HEDIS rates. As a result, establishing the connections to the data sources and streamlining this process took a priority focus over assessing the cost of producing these files against the impact on rates.

2016 Non-ABD Population Recommendations

HSAG recommended that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
  - *Children and Adolescents' Access to Primary Care Practitioners*
  - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- Children's Preventive Care
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications*
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
  - *Follow-Up After Hospitalization for Mental Illness*

Non-ABD Population Improvement Activities Implemented

AlohaCare QI's 2017 Provider Incentive Program targeted select HEDIS measures to help improve rates for the QUEST Integration populations. Providers were reimbursed for meeting the HEDIS criteria of

each measure that their members were selected for. The payment methodology was revised to better reward providers who improved year-over-year for the specified HEDIS measures. ABD and non-ABD populations were not distinguished in the Provider Incentive Program.

Incentivized HEDIS measures included:

- *Childhood Immunization Status—Combination 3*
- *Prenatal and Postpartum Care*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- *Comprehensive Diabetes Care*
  - *HbA1c Control (<8.0%)*
  - *Eye Exam (Retinal) Performed*

2016 ABD Population Recommendations

HSAG recommended that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the ABD population:

- Access to Care
  - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- Children's Preventive Care
  - *Adolescent Well-Care Visits*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- Women's Health
  - *Cervical Cancer Screening*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*

ABD Population Improvement Activities Implemented

Data systems and process: AlohaCare QI added additional supplemental data sources for HEDIS 2017 in the form of electronic medical record (EMR) feeds and data files from five community health centers. AlohaCare QI's focus centered on implementing the data extracts, satisfying the requirements of the Roadmap, obtaining auditor approval, and the testing of these data sources. AlohaCare QI's objective was to gather as much data as resources allowed for the HEDIS 2017 season and evaluate the rate impact by each supplemental data source file.

The benefit of AlohaCare QI's aggregation of data from its community health center partners goes beyond the impact on HEDIS rates. As a result, establishing the connections to the data sources and streamlining this process took a priority focus over assessing the cost of producing these files against the impact on rates.

CAHPS—Adult Survey

2016 Recommendations

Based on an evaluation of AlohaCare QI's results, the priority areas identified by HSAG were *Getting Needed Care*, *Customer Service*, and *Getting Care Quickly*.

Improvement Activities Implemented

Access to Care: AlohaCare QI removed the referral requirement for in-network specialist appointments, as of 8/1/2017, to better assist members and ensure they are receiving the care and services most appropriate for their healthcare needs. In addition, AlohaCare QI has strengthened its Transition of Care program through 2016/2017 to better facilitate coordination of required services for members experiencing a transition through care settings.

Timely Access to Care: The Provider Services department performed network analyses to identify provider shortages and access-to-care issues. The timely access survey targeted both providers and members. This survey is conducted on a quarterly basis and serves to gain feedback concerning the timely access to appointments and to measure appointment standard adherence. Based on survey outcomes, AlohaCare QI crafted a targeted provider education letter that was distributed to providers who did not meet the appointment standards. AlohaCare QI regularly publishes a provider newsletter that includes best practices for appointment standards. The GeoAccess report was used to identify network gaps specifically concerning member-to-provider ratio as well as deficiencies related to distance/miles. Recruiting strategies continue to be focused on addressing any network gaps identified in the report.

AlohaCare QI also implemented processes to decrease member no-shows. Specifically, AlohaCare QI has been working with targeted network providers concerning frequent appointment reminders, including reminders about necessary pre-appointment/visit preparation that a member is responsible for completing to ensure a successful medical visit. To eliminate added administrative burden, AlohaCare QI removed the specialist referral requirement, which sometimes led to a no-show or delay in receiving an appointment.

Customer Service: AlohaCare QI continued to develop its high-touch model of member engagement through 2017, and this will be fully implemented in 2018. All AlohaCare QI members will have a central lead, and this will be consistent across both Medicare and Medicaid lines of business.

The Customer Service department assesses its ability to adequately provide for member needs on an ongoing basis based on internal and State-specified Key Performance Indicators (KPIs). Monthly tracked measures (and acceptable standards) include:

- Call abandonment rate—five percent (5%) or less.
- Average speed of answer—thirty (30) seconds or less.
- Average hold time—two (2) minutes or less.
- Blocked call rate—does not exceed one percent (1%).
- Longest wait in queue—four (4) minutes or less.

AlohaCare QI's internal KPIs are consistent with Hawaii requirements and are tracked on an organizational dashboard, which is reported regularly.

The Customer Service department has also implemented an extensive training program that consists of benefits, service coordination, special projects, systems, non-ACD special projects, telephone training, and Medicare. A checklist is now given to each new customer service employee, and trainings are conducted on a yearly basis as a refresher. The training program was reviewed and is updated as necessary according to benefit and/or changes in the law.

Provider Survey

2016 Recommendations

The provider survey revealed opportunities to improve provider satisfaction. Based on these results, HSAG provided general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction.

- Providers consistently expressed concerns in getting adequate specialty care due to the lack of specialists. The process to refer patients to specialists was noted as especially difficult. The shortage of specialists on the island requires patients to travel to get care, but limitations related to availability and travel arrangements prevent many patients from being seen in a timely manner. Providers are becoming overwhelmed by the growing demand, while many members are being left with nowhere to go. HSAG recommends the QI health plans work with the MQD on a solution to this issue, such as provider recruitment and retention, and focus on the patient-centered medical home (PCMH) model of care.
- Some providers indicated that the prior authorization process has a negative impact on their ability to provide quality care. QI health plans could work toward programming medical services and drugs that require prior authorization into their systems and workflows to automate the process (e.g., expand availability and interoperability of health information technology). The QI health plans can work with the MQD to support the simplification and standardization of the preauthorization forms and process.

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- Providers' feedback indicated that opportunities still exist to ensure that QI health plans have adequate access to non-formulary drugs. QI health plans typically choose which drugs to include in the formulary. The QI health plans should consider working with the MQD to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
- Periodic provider focus groups could be implemented to gain further valuable information and insight into areas of poor performance as described in the survey feedback. Hearing about specific scenarios and examples of provider issues may help the QI health plans in understanding and targeting areas needing performance improvement. QI health plans could then use a performance improvement project approach to determine interventions and perform a targeted remeasurement of provider satisfaction at a later date.

Improvement Activities Implemented

In response to provider feedback and surveys, AlohaCare QI successfully removed the referral requirement for services rendered by network providers.

AlohaCare QI has also been working on improving its prior authorization requirements and processes, taking into consideration information received from providers via surveys as well as the practitioner advisory group. Unnecessary prior authorization requirements are being identified and removed where possible. AlohaCare QI will be implementing its revised authorization requirements, including an authorization look-up tool, in 2018.

HMSA Quest Integration (HMSA QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2016 QI Population Recommendations

HSAG recommended that HMSA QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- Children's Preventive Care
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

- Women's Health
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications*
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

QI Population Improvement Activities Implemented

Access to Care

HMSA QI's Online Care (HOC) offers members an alternative source to care with 24/7 telephone or web access to providers. HOC continued to expand and provide innovative services to members, including offering web consultations or follow-up appointments for certain specialties.

Another option available to members that improves access to care is urgent care providers located in clinics on Oahu, Maui, Hawaii Island, and Kauai. The urgent care clinics offer extended weekday, weekend, and holiday hours and can treat a wide range of conditions, except life-threatening emergencies.

In addition, HMSA QI continued to provide member education materials such as articles in its quarterly member magazine or line-of-business-specific newsletters to increase member awareness of their care options and to help members understand their role in obtaining appropriate care in a timely and satisfactory manner.

Effectiveness of Care

Medical Record Post-Discharge (MRP) template and training: In September 2016, HMSA QI created a standard template for providers to report medication reconciliation after inpatient discharge. The template was discussed with providers at a physician organization (PO) level through webinars and one-on-one as their patients became eligible for the measure. HMSA QI also worked with Queens Medical Center to discuss how providers can report and close gaps in their electronic medical record, Epic. In addition, HMSA QI did an advance review with Hawaii Pacific Health for sample medication reconciliation to use as a teach-back opportunity.

Children's Preventive Care

Pay-for-Quality and Payment Transformation: In 2016, HMSA QI' s Pay-for-Quality program continued to include the childhood immunization "combo 3," which included diphtheria, tetanus, pertussis, polio, mumps, measles, rubella, haemophilus influenza type b, hepatitis B, and varicella.

In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment transformation measures included *Childhood Immunization Status, Immunizations for Adolescents*, and *Weight assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*.

Mailers to parents: Mailers that included an immunization schedule and a well-child message were sent to parents of member ages 6, 12, and 15 months old. The members' providers were also sent a notification of the mailer.

Provider and member nurse reminder efforts: Continued from 2015, provider and member nurse reminder efforts involved providing vaccination status of members to providers. HMSA QI field staff and nurses outreached providers with their members' reports of vaccines received and not received. Vaccination reports for this intervention targeted members who turned 2 years of age from February to June 2015. In 2016, the second phase of this intervention used the data gathered from the first phase and identified members and providers at greater risk of not getting/providing vaccines. For these members, a nurse called and reminded the member's parent about the importance of immunizations and discussed potential barriers to receiving the vaccines. Providers were outreached to discuss processes and barriers based on potential issues raised by members.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): The EPSDT program outreached members and their parents about preventive care measures for newborns to 20 years of age. Outreach included well-child appointment reminder letters.

Other information available in this program included:

- Growth and development.
- Nutrition, physical activity, and safety.
- Early screening and treatment for medical or behavioral problems.
- Receiving vaccinations timely.

Women's Health

Pregnancy Support program: The Pregnancy Support program provided telephonic support to members from maternity registered nurses (RNs). Support included education, referrals, and encouragement to obtain regular prenatal and postpartum care. Members were identified through claims and were mailed an invitation and enrollment form. In addition, providers could refer their patients into the program.

HMSA QI published an article and advertisement in the *Island Scene* magazine providing resources for pregnant HMSA QI members.

***Your Pregnancy and Childbirth*:** This book provided information for pregnant women such as diet, exercise, and common questions or concerns related to pregnancy. The book was available as a maternity health resource to HMSA QI members at no cost.

Chronic Conditions

Pay-for-Quality and Payment Transformation: In 2016, HMSA QI's Pay-for-Quality program continued to include measures for *Comprehensive Diabetes Care* and *Controlling High Blood Pressure*.

In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment Transformation measures included *Comprehensive Diabetes Care* and *Controlling High Blood Pressure*.

Senior Fair outreach: In support of coordination of care with providers, HMSA QI offered a mini health clinic at the 2016 Senior Fair. The mini health clinic included blood pressure and body mass index (BMI) reading, as well as a flu shot clinic that HMSA QI co-sponsored with CVS. Health information such as blood pressure, flu vaccinations, and BMI were given as a hard copy to the member and another copy was mailed to the member's primary care provider. Kahu Malama nurses were involved in this outreach to potentially increase the likelihood of providers entering data into medical records.

Disease Management program: HMSA QI's Disease Management (DM) program aims to provide support to members through education materials and classes. Classes are free and are offered by HMSA QI and affiliated partners. In coordination with providers, HMSA QI's goal is to provide awareness of managing chronic conditions such as diabetes, asthma, chronic obtrusive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and hypertension.

Table 5-1—DM Program Groups (QI)

Group	Definition
Group 1	Well-controlled disease
Group 2	Not known to be in control
Group 3	Severe condition

Table 5-2 outlines specific outreach conducted in 2016.

Table 5-2—DM Outreach by DM Group (QI)

Member Group	Intervention	
Group 1 Well-controlled condition	All members in a disease state	Member: Annual condition-specific introduction letter, e.g., action plan
Group 2 Not known to be in control	a. Members whose provider belongs to a PO b. Members whose provider does not belong to a PO c. Members not attributed to a PCP	a. Provider: DM materials, support services, and member list to POST b. Provider: DM materials, support services and member list to POST c. Member: Referral to CareFinder; quarterly mailings based on condition specific information and action plan
Group 3 Severe condition	All members in a disease state	Member: In addition to the above interventions, outbound calls to either their PCP or to the member to ensure engagement, and/or coordination with Beacon Case Management, Care Mode, Special Health Care Needs (SHCN), Model of Care, and Long-Term Services and Supports (LTSS)

Behavioral Health

Aftercare program: Beacon continued its Aftercare program, which incorporates systematic ambulatory follow-up coordination services and quality management practices. The following were included in the Aftercare program:

- Coordination process began as soon as member was admitted for mental illness.
- Beacon Aftercare coordinator outreached to members via phone call to ensure follow-up appointment was made or to remind member to schedule a follow-up appointment.
- If coordinator was unable to reach member, a reminder letter was sent.
- Outreach to provider was made after appointment date to verify whether member attended follow-up appointment.
- If member did not attend follow-up or cancelled, coordinator outreached member to attempt to reschedule appointment.

Face-to-face engagement (pilot): Beginning in April 2016, in addition to the Beacon Aftercare program, Aftercare coordinators completed face-to-face outreach with members at Castle Medical Center at least twice a week. Face-to-face (F2F) engagement was done when members had an inpatient visit or on the day of discharge. HMSA QI collaborated with the line-level staff at the facility to ensure post-hospitalization follow-up care and assisted the facilities with discharge planning.

Beacon also launched pilots at the following facilities: Maui Memorial Medical Center, Hilo Medical Center, and Queens Medical Center.

The following table represents the process and outcome measure of this pilot activity by facility.

Table 5-3—Pilot Study Outcomes by Facility (QI)

Facility	Pilot Period Evaluated	Total Number of Members who had F2F Engagement	Percentage of Members Seen by SC/CC who Attended Their 7-day FUH
Castle	April 1–Dec 1	121	49%
Maui	May 1–July 31	9	33%
Hilo	May 1–July 31	11	82%
Queens	Sep 1–Nov 30	43	44%

2016 Non-ABD Population Recommendations

HSAG recommended that HMSA QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
- Children's Preventive Care
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- Women's Health
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications*

- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

Non-ABD Population Improvement Activities Implemented

Children's Preventive Care

Pay-for-Quality and Payment Transformation: In 2016, HMSA QI' s Pay-for-Quality program continued to include the childhood immunization "combo 3," which included diphtheria, tetanus, pertussis, polio, mumps, measles, rubella, haemophilus influenza type b, hepatitis B, and varicella.

In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment transformation measures included *Childhood Immunization Status*, *Immunizations for Adolescents*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.*

Mailers to parents: Mailers that included an immunization schedule and a well-child message were sent to parents of members who were 6, 12, and 15 months of age. The members' providers were also sent a notification of the mailer.

Provider and member nurse reminder efforts: An intervention that continued from 2015, provider and member nurse reminder efforts involved providing the vaccination status of members to providers. HMSA QI field staff and a nurse conducted outreach to providers with their members' vaccination reports of vaccines received and not received. Vaccination reports for this intervention targeted members who turned 2 years of age from February to June 2015. In 2016, the second phase of this intervention used the data gathered from the first phase and identified members and providers at greater risk of not getting/providing vaccines. For these members, a nurse called and reminded the members and their parents about the importance of immunizations and discussed potential barriers to receiving the vaccines. Providers were contacted to discuss processes and barriers based on potential issues raised by members.

EPSDT: The EPSDT program outreached members and their parents about preventive care measures for newborns to 20 years of age. Outreach included letters about well-child appointment reminders.

Other information available in this program included:

- Growth and development.
- Nutrition, physical activity, and safety.
- Early screening and treatment for medical or behavioral problems.
- Receiving vaccinations timely.

Women's Health

Pregnancy Support program: The Pregnancy Support program provided telephonic support to members from maternity RNs. Support included education, referrals, and encouragement to obtain regular prenatal and postpartum care. Members were identified through claims and were mailed an invitation and enrollment form.

HMSA QI also published an article and advertisement in the *Island Scene* magazine providing resources for pregnant HMSA QI members.

***Your Pregnancy and Childbirth*:** This book provided information for pregnant women such as diet, exercise, and common questions or concerns related to pregnancy. The book was available as a maternity health resource to HMSA QI members at no cost.

Chronic Conditions

Pay-for-Quality and Payment Transformation: In 2016, HMSA QI's Pay-for-Quality program continued to include measures for *Comprehensive Diabetes Care* and *Controlling High Blood Pressure*.

In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment Transformation measures included *Comprehensive Diabetes Care* and *Controlling High Blood Pressure*.

Senior Fair outreach: In support of coordination of care with providers, HMSA QI offered a mini health clinic at the 2016 Senior Fair. The mini health clinic included blood pressure and (BMI reading, as well as a flu shot clinic that HMSA QI co-sponsored with CVS. Health information such as blood pressure, flu vaccinations, and BMI were given as a hard copy to the member and another copy was mailed to the member's primary care provider. Kahu Malama nurses were involved in this outreach to potentially increase the likelihood of providers entering data into medical records.

DM program: HMSA QI's DM program aims to provide support to members through education materials and classes. Classes are free and are offered by HMSA QI and affiliated partners. In coordination with providers, HMSA QI's goal is to provide awareness of managing chronic conditions such as diabetes, asthma, COPD, CHF, CAD, and hypertension.

Table 5-4—DM Program Groups (Non-ABD)

Group	Definition
Group 1	Well-controlled disease
Group 2	Not known to be in control
Group 3	Severe condition

Table 5-5 outlines specific outreach conducted in 2016.

Table 5-5—DM Outreach by DM Group (Non-ABD)

Member Group	Intervention	
Group 1 Well-controlled condition	All members in a disease state	Member: Annual condition-specific introduction letter, e.g., action plan
Group 2 Not known to be in control	a. Members whose provider belong to a PO b. Members whose provider does not belong to a PO c. Members not attributed to a PCP	a. Provider: DM materials, support services and member list to POST b. Provider: DM materials, support services and member list to POST c. Member: Referral to CareFinder; quarterly mailings based on condition specific information and action plan
Group 3 Severe condition	All members in a disease state	Member: In addition to the above interventions, outbound calls to either their PCP or to the member to assure engagement, and/or coordination with Beacon Case Management, Care Mode, SHCN, Model of Care, and LTSS

<u>**Behavioral Health**</u>

Aftercare program: Beacon continued its Aftercare program, which incorporates systematic ambulatory follow-up coordination services and quality management practices. The following were included in the Aftercare Program:

- Coordination process began as soon as member was admitted for mental illness.
- Beacon Aftercare coordinator outreached to members via phone call to ensure follow-up appointment was made or to remind member to schedule a follow-up appointment.
- If coordinator was unable to reach member, a reminder letter was sent.
- Outreach to provider was made after appointment date to verify whether member attended follow-up appointment.
- If member did not attend follow-up or cancelled, coordinator outreached member to attempt to reschedule appointment.

Face-to-face engagement (pilot): Beginning in April 2016, in addition to the Beacon Aftercare program, Aftercare coordinators completed face-to-face outreach with members at Castle Medical Center at least twice a week. Face-to-face (F2F) engagement was done when members had an inpatient

visit or on the day of discharge. HMSA QI collaborated with the line-level staff at the facility to ensure post-hospitalization follow-up care and assisted the facilities with discharge planning.

Beacon also launched pilots at the following facilities: Maui Memorial Medical Center, Hilo Medical Center, and Queens Medical Center.

The following table represents the process and outcome measure of this pilot activity by facility.

Table 5-6—Pilot Study Outcomes by Facility (Non-ABD)

Facility	Pilot Period Evaluated	Total Number of Members who had F2F	Percentage of Members Seen by SC/CC who Attended Their 7-day FUH
Castle	April 1–Dec 1	121	49%
Maui	May 1–July 31	9	33%
Hilo	May 1–July 31	11	82%
Queens	Sep 1–Nov 30	43	44%

2016 ABD Population Recommendations

HSAG recommended that HMSA QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the ABD population:

- Access to Care
  - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- Children’s Preventive Care
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- Women’s Health
  - *Cervical Cancer Screening*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*

ABD Population Improvement Activities Implemented

Access to Care

Provider education and awareness: Early identification of alcohol or drug dependence allows for proper treatment planning. That planning includes regular follow-up meetings with a behavioral health practitioner. Beacon launched a campaign in April 2016 targeting the top 20 diagnosing behavioral health providers with a commercial population. HMSA QI's commercial population historically has significantly lower rates than QUEST Integration members. The top 20 providers were identified based on HEDIS 2016 specifications, which measured members with an alcohol and other drug (AOD) dependence identified from January 1, 2015, to November 15, 2015. The top 20 providers by volume of members accounted for 491 of 990 commercial members with an average initiation rate of 49.5 percent.

Some of the key features of the activity included:

- Telephonic outreach and face-to-face office visits to identify high-volume BH OP providers.
- Mailings to providers with satisfactory performance.
- Reminders on the importance of early identification and treatment of substance use disorders.
- Shared provider-level data that included HEDIS rates with member-level detail.
- Dissemination of provider tools (Behavioral Health/Substance Abuse Referral Form, Leave-Behind Card with Beacon/HMSA QI contact information, and approved patient educational materials).

The top 20 diagnosing providers' *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* initiation and engagement rates were measured pre- and post-implementation using Beacon-Hawaii's local HEDIS proxy program. The results indicated IET initiation rates improved for 11 providers, while eight provider IET initiation rates declined. IET engagement rates improved for eight providers, while eight provider engagement rates declined. The volume of eligible members by provider also declined.

Furthermore, Beacon continued to raise awareness around the IET measure at the quarterly Provider Advisory Council (PAC) meetings and facilitated discussion regarding the measure with the behavioral health providers in attendance. This forum occurred on June 16, 2016, where best practices were shared, and the importance of early identification and treatment of substance use disorders was discussed.

PCP Record Reviews (Pilot): Beacon launched a pilot activity and conducted chart reviews on IET-eligible members who had a visit to a PCP within 14 days of when they were diagnosed. The purpose of the chart reviews was to identify if there were appropriate treatment plans for AOD dependence documented by the PCP. Data analysis was conducted on IET-eligible members with initial diagnosis dates between January 1, 2016, and April 9, 2016, which identified that 22 percent (2,639) of IET-eligible members had a visit to a PCP within 14 days of the Index Episode Start Date (IESD). However, only 4 percent initiated treatment.

Beacon requested a total of 46 records from various PCP offices and received a total of 29 records (63 percent). The records reviewed indicated that 24 percent of members had evidence in the clinical notes

that the PCP initiated an appropriate treatment plan; however, this was not captured in the claim due to absence of an AOD diagnosis code. Other reviews conducted indicated there was no evidence that the PCP addressed AOD dependence or initiated treatment for the member. Based on the findings of the pilot, there is an opportunity to collaborate with PCPs on appropriate treatment steps when alcohol or drug dependence is identified. This is also an opportunity to remind providers to list all applicable diagnosis codes when submitting a claim.

Effectiveness of Care

MRP template and training: In September 2016, HMSA QI created a standard template for providers to report medication reconciliation after inpatient discharge. The template was discussed with providers at a PO level through webinars and one-on-one as their patients became eligible for the measure. HMSA QI also worked with Queens Medical Center to discuss how providers can report and close gaps in their electronic medical record, Epic. In addition, HMSA QI did an advance review with Hawaii Pacific Health for sample medication reconciliation to use as a teach-back opportunity.

Children's Preventative Care

Payment Transformation: In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment transformation measures included *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*.

EPSDT: The EPSDT program reached out to members and their parents about preventive care measures for newborns to members 20 years of age. Outreach included reminder letters for well-child appointments.

Other information available in this program included:

- Growth and development.
- Nutrition, physical activity, and safety.
- Early screening and treatment for medical or behavior problems.
- Receiving vaccinations timely.

Chronic Conditions

Pay-for-Quality and Payment Transformation: In 2016, HMSA QI's Pay-for-Quality program continued to include measures for *Comprehensive Diabetes Care* and *Controlling High Blood Pressure*.

In 2016, HMSA QI launched the value-based Payment Transformation program with a pilot set of provider offices. Payment Transformation measures included *Comprehensive Diabetes Care* and *Controlling High Blood Pressure*.

Senior Fair outreach: In support of coordination of care with providers, HMSA QI offered a mini health clinic at the 2016 Senior Fair. The mini health clinic included blood pressure and BM) reading, as well as a flu shot clinic that HMSA QI co-sponsor with CVS. Health information such as blood pressure,

flu vaccinations, and BMI were given as a hard copy to the member and another copy was mailed to the member's primary care provider. Kahu Malama nurses were involved in this outreach to potentially increase the likelihood of providers entering data into medical records.

DM program: HMSA QI's DM program aims to provide support to members through education materials and classes. Classes are free and are offered by HMSA QI and affiliated partners. In coordination with providers, HMSA QI's goal is to provide awareness of managing chronic conditions such as diabetes, asthma, COPD, CHF, CAD, and hypertension.

Members are put into different groups based on emergency or inpatient use, complications, comorbidity, and control value.

Table 5-7—DM Program Groups (ABD)

Group	Definition
Group 1	Well-controlled disease
Group 2	Not known to be in control
Group 3	Severe condition

Table 5-8 outlines specific outreach conducted in 2016.

Table 5-8—DM Outreach by DM Group (ABD)

Member Group	Intervention	
Group 1 Well controlled condition	All members in a disease state	Member: Annual condition-specific introduction letter, e.g., action plan
Group 2 Not known to be in control	a. Members whose provider belong to a PO b. Members whose provider does not belong to a PO c. Members not attributed to a PCP	a. Provider: DM materials, support services and member list to POST b. Provider: DM materials, support services and member list to POST c. Member: Referral to CareFinder; quarterly mailings based on condition specific information and action plan
Group 3 Severe condition	All members in a disease state	Member: In addition to the above interventions, outbound calls to either their PCP or to the member to ensure engagement, and/or coordination with Beacon Case Management, Care Mode, SHCN, Model of Care, and LTSS

Behavioral Health

Aftercare program: Beacon continued its Aftercare Program, which incorporates systematic ambulatory follow-up coordination services and quality management practices. The following were included in the Aftercare program:

- Coordination process began as soon as member was admitted for mental illness.
- Beacon Aftercare coordinator outreached to members via phone call to ensure follow-up appointment was made or to remind member to schedule a follow-up appointment.
- If coordinator was unable to reach member, a reminder letter was sent.
- Outreach to provider was made after appointment date to verify whether member attended follow-up appointment.
- If member did not attend follow-up or cancelled, coordinator outreached member to attempt to reschedule appointment.

Face-to-face engagement (pilot): Beginning in April 2016, in addition to the Beacon Aftercare program, Aftercare coordinators also completed face-to-face outreach to members at Castle Medical Center at least twice a week. Face-to-face engagement was done when members had an inpatient visit or on the day of discharge. HMSA QI collaborated with the line-level staff at the facility to ensure post-hospitalization follow-up care and assisted the facilities with discharge planning.

Beacon also launched pilots at the following facilities: Maui Memorial Medical Center, Hilo Medical Center, and Queens Medical Center.

The following table represents the process and outcome measure of this pilot activity by facility.

Table 5-9—Pilot Study Outcomes by Facility (ABD)

Facility	Pilot Period Evaluated	Total Number of Members who had F2F	Percentage of Members Seen by SC/CC who Attended Their 7-day FUH
Castle	April 1–Dec 1	121	49%
Maui	May 1–July 31	9	33%
Hilo	May 1–July 31	11	82%
Queens	Sep 1–Nov 30	43	44%

CAHPS—Adult Survey

2016 Recommendations

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

Improvement Activities Implemented

Customer Service

Call centers: In addition to 24/7 general call center access and after-hours access to QUEST Integration executive staff for urgent situations, HMSA QI provides a 24-hour nurse advice line that members can call to talk with a nurse, get questions answered, and determine whether a member should see a doctor or go to the emergency room. HMSA QI's 24-hour nurse advice line can also refer a member to a participating provider.

With regard to call center training, QUEST Call Center management staff continued to conduct a 15-minute meeting with call center representatives each morning, using this time to review issues that were identified via member and provider calls, updates regarding current mailings to members and providers, provider/network issues, and any other recurring issues identified by staff or management that all representatives needed to be informed of. Weekly one-hour trainings were also conducted for more in-depth topics that included improvement opportunities identified from member and provider calls, new or revised benefit and system changes, or process improvement implementation efforts.

Cultural competency focused training: HMSA QI is committed to continually improving and enhancing the level of service provided to its members through ongoing training focusing on the unique needs of its membership. HMSA QI recognizes the cultural diversity of its membership and has focused training efforts around this. In 2017, HMSA QI partnered with a consultant who had significant experience engaging with culturally diverse populations to conduct cultural competency training. Over the course of two months, six training sessions were provided (two on the neighbor islands, two in Kapolei, one at the HMSA QI offices in Kaimuki, and one at the HMSA QI Center) to further support HMSA QI's efforts to communicate with its QUEST Integration members in a meaningful way that takes into account the diverse and multicultural, beliefs, values, health practices, and socioeconomic needs of the population.

The training, entitled "The Pacific Islander Experience Cultural Competency Training," focused on cultural sensitivity and how western vs. native ideals impact perception. The sessions were extremely successful with more than 135 HMSA QI employees across the organization from medical management, service coordination, customer service, and program administration in attendance. Those attending were asked to complete a short satisfaction survey—results are shown below.

Table 5-10—Satisfaction Survey Results

Overall Workshop	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The purpose of the training was clearly communicated.			1	27	107
2. The slides and materials enhanced the presentation.			3	40	91
3. The training effectively engaged the audience.			0	19	116
4. The trainer spoke clearly and effectively.			1	13	121
5. I learned at least one new skill, attitude, or idea.			3	21	111
6. It made me think of things in a new way or see a different perspective.			2	28	105
7. I found the training to be beneficial to my life and my work.			2	23	110

Comments regarding what attendees found most helpful included:

- "The personal stories/real life examples"
- "Reminds (me) of (our) purpose"
- "Felt connected to presenters"
- "Reconnection with culture"
- "This was one of the most powerful 'trainings' that I've EVER attended. It spoke to us as people and united us (member/Service Coordinator) in a way that we have not been before."
- "One of the Best Trainings I've ever had"

Based on the success of these cultural competency training sessions, HMSA QI is exploring ways to ensure that what was learned during these sessions is remembered and put into practice throughout the year in order to optimize communication, engagement, and connections to HMSA QI members, providers, and among staff.

Customer service performance measures: HMSA QI has established plan-level customer service standards that are consistent with MQD requirements with regard to both member and provider call centers. Results of these monitoring metrics, which include call volume, average speed of answer, and abandonment rates, are reviewed and discussed monthly at the highest levels (e.g., the HMSA QI QUEST Integration Executive Steering Committee) to ensure that HMSA QI continues to meet the needs of its members and providers.

Access and Availability to Care

Patient access and availability: HMSA QI conducts quarterly surveys of both members and providers to determine access to primary, specialty, and behavioral care for the following types of visits: adult sick, urgent care appointment, pediatric sick, routine PCP, routine behavioral health, specialist, and non-emergency hospital stays.

Results over the past year have shown that appointment access for child/pediatric specialist visits warrants further investigation and has negatively impacted HMSA QI's overall CAHPS *Getting Needed Care* composite measure. Analysis is in process to identify the top high-volume specialists and conduct a rapid-cycle improvement activity focused on specialty appointment access.

HMSA QI also uses geo mapping and other data analytic tools to convert the vast amounts of data into actionable information. Beyond the conventional participating provider penetration reports, turnover ratios, geo-access reports, and geo-access maps, HMSA QI further analyzes its networks by specialty, patient panel size, drive times, appointment wait times, and other important criteria identified by members and customers. HMSA QI also has several ongoing programs to build primary and specialty care to ensure availability of providers representing primary and specialty care for members on the neighbor islands:

- A recruitment package for neighbor island hospitals, Federally Qualified Health Centers (FQHCs), and clinics, and medical group subsidies to cover the costs of physician recruitment, allowing physician groups and hospitals to offer more attractive arrangements to prospective physicians.
- Provider practice start-up cost subsidies help providers set up their practice by giving them a source of revenue while they are building their business. This incentivizes physicians to set up independent practices on the neighbor islands. This program helped a primary care physician on Oahu relocate to Hawaii Island.
- HMSA QI provides travel subsidies to specialists who are willing to travel to the neighbor islands. This improves access to specialty care providers in rural areas that cannot sustain specialists on their own.
- HMSA QI provides support to the Queens and Straub specialty clinics as well as individual providers, all of whom are available to see QI members. The traveling specialists help to fill specialty shortages, such as nephrology (Hilo, Kona, Waimea, Kauai, Lanai, and Kona); otolaryngology (Kona); neurosurgery (Hilo, Kona); orthopedic surgery (Hilo, Kona, Waimea, Maui and Kauai); rheumatology (Hilo, Kauai); ophthalmology (Hilo); and gastroenterology (Maui); as well as oncology, obstetrics/gynecology, cardiology, and endocrinology.

Decrease no-show appointments*:* To decrease no-show appointments, providers can refer their patients for service coordination. The assigned service coordinator will assist the member in identifying barriers, developing a service plan, and coordinating services that will support the member's needs and reduce no-shows.

Coordination of Care

HMSA QI has established a service coordination program to ensure the appropriate identification and engagement of HMSA QI QUEST Integration members into service coordination, to ensure that members with SHCN, those who are dually eligible, at-risk, or those needing LTSS receive the best possible care and service.

The service coordination system uses a member-centric, holistic approach to coordinate care for members across all providers and settings, evaluating all options and services available to meet members' healthcare needs as well as promoting quality outcomes. This includes developing strategies for meeting the needs of members with both medical and behavioral health conditions.

HMSA QI continued to promote the use of technology to improve the health and well-being of its members in a variety of ways. Cozeva is a web-based platform that promotes communication between providers and their patients. It allows providers to see their HMSA QI quality measures and correlating patient information. Through Cozeva, they are able to identify gaps in care and address them in an upcoming visit. In the event a member needs to see a specialist, PCPs can ensure their patients can get the appropriate care by using Cozeva to create/track referrals and request/track prior authorizations. In addition, members can review prior authorization requests, status, and decisions through Cozeva's member platform. For members who are in HMSA QI Service Coordination, PCPs can view their patient's care plan in order to most effectively work with the member's service coordinator to assure that care plan goals are being met.

In 2017, HMSA QI also launched an innovative new mobile application called Sharecare, which gives members easy access to a variety of tools and trackers to help them keep all their health information in one place and to motivate members to manage their own health and well-being. Some of the app's features include: finding a doctor, AskMD, the "Real Age" assessment, and trackers that link to Fitbit and other health-related iOS/android fitness apps. HMSA QI will continue to evolve this innovative technology to most effectively engage members about their health in a personalized way that is most relevant and comfortable for them.

Provider Survey

2016 Recommendations

The provider survey revealed opportunities to improve provider satisfaction. Based on these results, the following are general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction. HMSA QI's performance was not statistically different than the aggregate performance of other plans in the areas of Formulary, Access to Non-Formulary Drugs, Helpfulness of Service Coordinators and Adequacy of Behavioral Health Specialists. These general recommendations should be evaluated in the context of each plan's operational and quality improvement activities.

Improvement Activities Implemented

To maintain and improve provider satisfaction, HMSA QI has implemented the following:

Medical management—prior authorizations: Staff dedicated to improving electronic prior authorizations (iExchange). Over the last two years, HMSA QI has dedicated staff to training and educating providers (via phone, online meetings, and face to face) regarding the use of HMSA QI's electronic precertification processes called iExchange. This electronic precertification portal enables providers to submit their requests electronically, provides an avenue to submit additional clinical information if needed, and improves the overall precertification review/decision experience.

As a result of education and training efforts, the use of iExchange (as of July 2017) has increased to more than 350 requests per month compared to 200 per month during the same period last year. Providers who have transitioned from paper to electronic precertification have been extremely positive, citing the speed of decision making as well as the ability to upload large clinical records to support the precertification request electronically as the primary reasons.

HMSA QI will continue to expand the use of electronic precertifications through iExchange and enhance these capabilities as part of improving this shared workflow between providers and HMSA QI.

Formulary Management

Prior authorizations/step therapies/addition of non-formulary drugs: HMSA QI uses an evidence-based prior authorization program that ensures its members receive the most appropriate medications that are safe, effective, and provide the greatest value (i.e., reducing waste, unnecessary drug use, and cost). Prior authorization criteria are reviewed and updated regularly to ensure they are working as intended and to minimize the burden on providers and members as well as to ensure member access to drugs. Over the past year, HMSA QI as made several changes based on ongoing review as noted below:

- Amicar, Premarin® vaginal cream, and levocarnitine were added to the HMSA QI formulary since they had high non-formulary exceptions approval rates.
- Step therapy was removed from Advair since it had a high prior authorization volume and high approval rate.
- Flovent was added to the HMSA QI formulary based on feedback received from pediatricians in the community.
- Zolpidem ER was added to the HMSA QI formulary to provide a long-acting sleep aid on the formulary.
- Prior authorization was removed from Suboxone to ensure members with opiate agonist dependence have easy access to this drug.

Specialty drug online prior authorizations: Providers who need prior authorization for a medical specialty drug can submit their request through NovoLogix, an online prior authorization tool. Online prior authorizations save providers time and reduce the need to phone or fax prior authorization requests for medical specialty drugs because the system allows them to:

- Easily create a request online.
- Track the authorization status online.
- View request determinations in NovoLogix.

Physician organization pilot: HMSA QI is working with physician organizations to pilot a program in which pharmacists would work with providers to offer pharmacist support. Part of the resource will be for pharmacists to help providers with prior authorizations and educate them on the formulary process. This program will help minimize prior authorizations and the administrative burden associated with them.

Provider recruitment/network management: Recruitment support for hospitals, medical groups, and FQHCs to assist with efforts to attract additional providers to the neighbor islands. HMSA QI has paid for recruiter fees, moving expenses, practice start-up expenses, and travel for interviews. This support, unique among Hawaii health plans, has been instrumental in adding to the PCP and specialist complement on the neighbor islands.

HMSA QI is actively working with existing providers or provider organizations on expanding access to primary and specialty care on the neighbor islands. HMSA QI has established relationships with neighbor island provider entities that recruit physicians, and recruitment support is dependent on the organizations undertaking activities to hire new providers. HMSA QI continues to fund this initiative in 2017, with these recent additions to the provider network:

- North Hawaii—one obstetrician/gynecologist (OB/GYN), one general surgeon, one otolaryngologist
- West Hawaii—one advanced practice registered nurse (APRN),
- East Hawaii—one pediatrician, one APRN
- Kauai—one urologist, one infectious disease specialist, one OB/GYN, one gastroenterologist
- Maui—one OB/GYN, one APRN

Funding a subsidy for travel by Oahu specialists to the neighbor islands: In a continuation of a successful program that enhances access to care, HMSA QI paid travel subsidies at $170 ($190 to Hilo) per roundtrip to specialists who traveled from Oahu and provided care on the neighbor islands. This program continues to have active participation by HMSA QI traveling specialists. From January to May 2017, HMSA QI paid stipends for 690 neighbor island trips.

The traveling specialists continue to help to fill specialty shortages, such as nephrology (Hilo, Kona, Waimea, Kauai, Lanai, and Kona); otolaryngology (Kona); neurosurgery (Hilo, Kona); orthopedic surgery (Hilo, Kona, Waimea, Maui and Kauai); rheumatology (Hilo, Kauai); ophthalmology (Hilo); and gastroenterology (Maui); as well as oncology, obstetrics/gynecology, cardiology, and endocrinology.

In communities that are not large enough to support specialty services, the traveling specialist program has brought needed specialty care. HMSA QI continues to work with health systems on care delivery models that might include more regularly scheduled specialty care or expanded use of telehealth.

Physician liaison committees: Three times a year, HMSA QI Provider Services management and medical directors conduct Physician Liaison Committee meetings with eight geographic groups of physicians in Honolulu, Windward Oahu, West Oahu, Hilo, Kona, North Hawaii, Maui, and Kauai. HMSA QI uses the Physician Liaison Committee meetings as a forum to gather physician feedback and input on processes and programs that need improvement. Specialty shortages and challenges with patient travel from the neighbor islands are among the issues that have been raised by doctors at these meetings.

Payment Transformation

HMSA QI has and will continue to invest significant resources (people, tools, and technology) to refine and improve value-driven healthcare through its Payment Transformation initiative, which aims to transition all PCPs into a new value-based payment model that will reward physicians for improvements in health and well-being, patient satisfaction, timely access to care, and care efficiency. HMSA QI's Payment Transformation pilots began in April of 2016 with a goal of having 100 percent of all PCPs reimbursed under this model by 2018. The new Payment Transformation model will tie a larger portion of each provider's reimbursement to meeting population health and wellness goals, including measures related to access to, and the cost and quality of, care.

The Payment Transformation program pays physicians a per member per month amount based on the number of attributed patient lives. The program encourages PCPs to more willingly accept QUEST Integration members and to effectively coordinate and manage their care.

As part of Payment Transformation, HMSA QI worked with neighbor island medical groups involved in primary care to support their urgent care services. In recognition of the need for care options on the neighbor islands, HMSA QI also contracted with specific PCPs to continue providing specialty care while being reimbursed a global monthly payment as a PCP.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2016 QI Population Recommendations

HSAG recommended that KFHP QI focus on improving performance related to the following measure with rates that fell below the national Medicaid 25th percentile for the QI population:

- Care of Chronic Conditions
  - *Medication Management for People With Asthma*

QI Population Improvement Activities Implemented

The following table depicts the three-year trend results for *Medication Management for People With Asthma* measure recommended for improvement. HEDIS 2017 results indicate that improvement was achieved during 2016 measurement.

Table 5-11—*Medication Management for People With Asthma* (MMA) for the QI Population: HEDIS 2015–2017

MMA Indicator	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate
Total Medication Compliance 50%	33.75%	35.75%	42.02%
Total Medication Compliance 75%	13.25%	15.46%	18.59%

An evaluation of the activities implemented as part of KFHP QI's quality improvement process is outlined as follows:

Improvement has been seen in both the 50 percent compliance rate and the 75 percent compliance rate.

Activities conducted include the following:

- Education by clinical pharmacy specialist in the third quarter of 2016 was provided to providers who were prescribing more than one short-acting beta agonist or as needed (prn) refills.
- During the first quarter of 2016, education was provided to clinical pharmacists and QUEST Integration RN case managers to review treatment algorithms and the asthma control test. Asthma control test scores are used to assess clinical control. Results of the asthma control test were plotted on the treatment algorithm to determine follow-up treatment. Depending on the score, asthma controller medication usage was started, increased, or decreased.
- Reprioritizing of job duties for clinical pharmacists to monitor appropriateness of asthma medication management.
- Physician specialist performed chart reviews and sent notices to PCPs to educate members regarding asthma management.

2016 Non-ABD Population Recommendations

HSAG recommended that KFHP QI focus on improving performance related to the following measure with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Care for Chronic Conditions
  - *Medication Management for People With Asthma*

Non-ABD Population Improvement Activities Implemented

The following table depicts the three-year trend results for *Medication Management for People With Asthma* measure recommended for improvement. The non-ABD population was carved out only for HEDIS 2016. Displayed in total QI population, the HEDIS 2017 results indicate that improvement was achieved during 2016 measurement.

Table 5-12—*Medication Management for People With Asthma* (MMA) for the Non-ABD Population: HEDIS 2015–2017

MMA Indicator	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate
Total Medication Compliance 50%	33.75%	35.75%	42.02%*
Total Medication Compliance 75%	13.25%	15.46%	18.59%*

* HEDIS 2017 reporting required only reporting of Total QI population. Non-ABD population carve out was not required.

Improvement has been seen in both the 50 percent compliance rate and the 75 percent compliance rate.

An evaluation of the activities implemented as part of KFHP QI's quality improvement process is outlined as follows:

- Education by clinical pharmacy specialist in the third quarter of 2016 was provided to providers who were prescribing more than one short-acting beta agonist or prn refills.
- During the first quarter of 2016, education was provided to clinical pharmacists and QUEST Integration RN case managers to review treatment algorithms and the asthma control test. Asthma control test scores are used to assess clinical control. Results of the asthma control test were plotted on the treatment algorithm to determine follow-up treatment. Depending on the score, asthma controller medication usage was started, increased, or decreased.
- Reprioritizing of job duties for clinical pharmacists to monitor appropriateness of asthma medication management.
- Physician specialist performed chart reviews and sent notices to PCPs to educate members regarding asthma management.

2016 ABD Population Recommendations

There were no recommendations for the 2016 ABD results; no improvement activities were implemented.

CAHPS—Adult Survey

2016 Recommendations

Based on an evaluation of KFHP QI's results, the priority areas identified were *Getting Needed Care*, *Customer Service,* and *Getting Care Quickly.*

Improvement Activities Implemented

Access to Care

KFHP QI uses encounter data to identify members from all plans who have care gaps to conduct both in-reach and outreach activities (equivalent to "max-packing"). The Mana Ku Tool, How Are We Doing (HAWD) Tool, and Super-list Population Outreach Tool (SPOT) draw data from KFHP QI's electronic medical records (HealthConnect) to identify members in need of prevention screenings such as cancer screenings, immunizations, chronic care services, or medication follow-up.

- **In-reach activity:** Any member who is physically present in the clinic for an appointment will have their "Mana Ku" profile opened, and the medical assistant will "pend" any due/overdue prevention screenings or care monitoring tests for the provider to review and order.
- **Outreach activity:** KFHP uses Mana Ku and HAWD to generate lists of patients who are due or overdue for prevention screenings, laboratory tests, chronic disease management, or medication management. Staff will perform targeted outreach to members via emails, letters, and/or phone calls (both live and by IVR technology). In addition to staff outreach, with information from HAWD and Mana Ku, KFHP QI can "batch" outreach for laboratory tests and screening tests.

The Patient Support Service (PSS) is a model for population care that uses the skills of clinical pharmacists, pharmacy technicians, advance practice RNs, registered nurses, medical assistants, and clerical staff to support physicians, help reach defined quality goals, and assist with regional priorities through an evidence-based, whole member care approach to improve the health status of patients with chronic illnesses.

The PSS team currently helps manage patients with chronic conditions including diabetes, hypertension and cardiovascular disease, gout, osteoporosis, depression, and other conditions. The team uses several tools including the Care Management Tracking System (CMTS), HAWD, and Mana Ku to provide real time data on targeted populations for feedback, monitoring, and management of the quality of care being delivered as measured against regional clinical standards.

Customer Service

Member Services performance of telephone access is monitored daily, and performance metrics are set to the MQD requirements to monitor compliance. Noncompliance metrics are analyzed for root cause, and corrective actions are taken.

Timely Access to Care

2016 primary care improvement activities included the following:

- Open panels and direct online booking for members
- Primary care appointments for routine office visits, same-day visits, and phone appointments
- Appointments for same-day care provided by PAs or physicians other than member's PCP
- Appointments to check vital signs, including blood pressure and weight
- Pediatric well-child visits and telephone appointments
- Extended after-hours care and urgent care hours
- Telephone appointments
- Secure messaging
- Internal medicine residency program

2016 specialty care improvement activities:

- Member direct online booking for select specialty care appointments (sports medicine, physical therapy consults)
- Telederm and flexible provider scheduling templates

The Strategy and Operations Work Team was developed to leverage and optimize telehealth visits based on which technology fits best for the respective specialty or visit type. These strategies will be used with MQD members now that telehealth has been approved in 2017.

Provider Survey

2016 Recommendations

The provider survey revealed opportunities to improve provider satisfaction. Based on these results, the following are general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction. These general recommendations should be evaluated in the context of each plan's operational and quality improvement activities.

- Providers consistently expressed concerns in getting adequate specialty care due to the lack of specialists. The process to refer patients to specialists was noted as especially difficult. The shortage of specialists on the island requires patients to travel to get care, but limitations related to availability and travel arrangements prevent many patients from being seen in a timely manner. Providers are becoming overwhelmed by the growing demand, while many members are being left with nowhere to go. HSAG recommends the QI health plans work with the MQD on a solution to this issue, such as provider recruitment and retention, and focus on the patient-centered medical home (PCMH) model of care.

- Some providers indicated that the prior authorization process has a negative impact on their ability to provide quality care. QI health plans could work toward programming medical services and drugs that require prior authorization into their systems and workflows to automate the process (e.g., expand availability and interoperability of health information technology). The QI health plans can work with the MQD to support the simplification and standardization of the preauthorization forms and process.
- Providers' feedback indicated that opportunities still exist to ensure that QI health plans have adequate access to non-formulary drugs. QI health plans typically choose which drugs to include in the formulary. The QI health plans should consider working with the MQD to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
- Periodic provider focus groups could be implemented to gain further valuable information and insight into areas of poor performance as described in the survey feedback. Hearing about specific scenarios and examples of provider issues may help the QI health plans in understanding and targeting areas needing performance improvement. QI health plans could then use a performance improvement project approach to determine interventions and perform a targeted remeasurement of provider satisfaction at a later date.

Improvement Activities Implemented

As noted in the CAHPS section, KFHP QI has implemented several activities to improve access to specialists and behavioral health providers. The number of specialty providers that members can directly book online has been increased. Expanded use of programs like telederm and flexible provider scheduling templates have increased panel capacity for specialists. The Strategy and Operations Work Team was developed to leverage and optimize telehealth visits based on which technology fits best for the respective specialty or visit type. These strategies will be used with MQD members now that telehealth has been approved in 2017.

Behavioral Health

Efforts to fill staffing vacancies were a top priority in 2016, along with growing the network of external providers. The Integrated Behavioral Health (IBH) department aggressively and proactively recruited to fill vacant positions; however, IBH continued to experience challenges due to the nationwide shortage. Throughout 2016, the strategy remained the same, which was to fill internal staffing vacancies, grow the network of external providers, and refer members out to external providers as needed. KFHP QI has partnered with Staffing Temp Agencies for internal staffing needs.

KFHP QI continued to use the patient-centered medical home (PCMH) model of care as a guiding principle. The organization is currently recognized at the highest level of status (Level 3) and is in the process of renewing its recognition of all 15 primary care sites under the 2017 redesigned program.

HSAG HEALTH SERVICES ADVISORY GROUP

‘Ohana Health Plan QUEST Integration (‘Ohana QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2016 QI Population Recommendations

HSAG recommended that ‘Ohana QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
  - *Children and Adolescents' Access to Primary Care Practitioners*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- 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*
  - *Chlamydia Screening in Women*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness*

QI Population Improvement Activities Implemented

‘Ohana QI's Quality Improvement Intervention Workgroup (QIIW) and Quality Improvement (QI) Team HEDIS Focus Workgroup met regularly to review trending data for HEDIS measures, complete causal barrier analysis, and monitor status updates of interventions developed specifically to improve HEDIS rates. Smaller workgroups were developed to address specific HEDIS measures, such as behavioral health, and measures related to women's and children's health. The following are improvement activities that were continued in 2016:

- ‘Ohana QI continued to receive lab results directly from lab vendors Clinical Laboratories and Diagnostic Laboratory Services.

- HEDIS practice advisors (HPAs), currently known as Quality Practice Advisors (QPAs), conducted quality-focused provider visits. In partnership with the provider relations representatives (PR reps), providers received education and coaching on HEDIS measures and how to improve rates. The HPA and/or PR reps distributed HEDIS tool kits and care gap reports to providers and taught providers how to use the HEDIS online tool (via provider portal) as an additional method to look up members' care gaps and close care gaps by submitting medical records through the online tool.
- A pay-for-performance bonus program was offered to certain provider groups.
- During the 2017 HEDIS season, 'Ohana QI contracted approximately sixteen (16) temporary staff to collect medical record data and conduct the over-reads used for HEDIS. 'Ohana QI also contracted an external vendor, Altegra, for the abstraction of medical records used for HEDIS for both Oahu and the neighbor islands. Six of the total temporary contracted staff were registered nurses (RNs) who focused mainly on inter-rater reliability (IRR) or over-reads of medical records. From this effort, 'Ohana QI exceeded its targeted 2017 goal from 85 percent to 96 percent of medical record retrieval.
- 'Ohana QI RNs conduct the annual medical record review (AMRR) audit and assess compliance with the plan's medical record standards and EPSDT documentation standards.
- Articles for both member and provider newsletters were published for the following: Chronic condition management, well-visits for children and adolescents, immunizations, women's health, prenatal and postpartum care, and behavioral health. 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 gap reports, and a scorecard was used to monitor the CCMA's progress in closing care gaps.
- A preventive care checklist that incorporated HEDIS-related preventive screenings was distributed to all members assigned to a service coordinator (SC). The reader-friendly checklist doubled 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 and disease management nurses discussed the checklist with members and instructed them to bring the checklist to their doctor's office during a follow-up visit for completion.
- Letters were mailed to providers to address members who have persistent asthma (based on claims data) and are on a controller medication. The letter included recommendations and a reminder to outreach the member to schedule a doctor's appointment.
- Mommy Baby Matters booklets, which included educational information on prenatal and postpartum care, were mailed out to pregnant members.
- Several outreach programs to educate members on chronic condition management and preventive screenings were completed. The following lists 'Ohana QI's various outreach programs:
  - The Centralized Telephonic Outreach program consisted of a vendor, Results, conducting calls to members with HEDIS care gaps and assisting them with scheduling an appointment with their physician and arranging transportation when needed.
  - The EPSDT coordinator and SCs outreached parents and guardians of pediatric members to educate and assist them with scheduling appointments for well-visits and to get their immunizations updated.

'Ohana QI's comparison rates of HEDIS 2016 to the HEDIS 2017 rates for the relevant measures that have improved are as follows:

Table 5-13—HEDIS Measure Rate Trend Analysis—Improvement between 2016 and 2017

Measure	HEDIS 2017 Rate	HEDIS 2016 Rate	% Point Improvement	% Improvement
Children's Access 17 (CAP17) Members 12 to 24 Month of Age	89.25%	85.25%	4.70%	5.51%
Chlamydia Screen 17 (CHL17) Total	53.06%	50.15%	2.91%	5.80%
Follow-Up Hosp MH 17 (FUH17) Follow-Up within 30 days	61.17%	43.73%	17.44%	39.88%
Follow-Up Hosp MH 17 (FUH17) Follow-Up within 7 days	37.80%	24.71%	13.09%	52.97%
Freq Ongoing PNC 17 (FPC27) <21 percent of expected visits	14.60%	12.53%	2.07%	16.52%
Freq Ongoing PNC 17 (FPC27)—60 percent of expected visits	11.92%	11.08%	0.84%	7.58%
Prenatal Post Care 17 (PPC27) Timeliness of prenatal care	76.40%	69.16%	7.24%	10.47%
Well-Child 15 Month 17 (W1517) Four well-child visits	9.94%	7.32%	2.62%	35.79%
Well-Child 15 Month 17 (W1517) One well-child visit	4.70%	3.79%	0.91%	24.01%
Well-Child 15 Month 17 (W1517) Three well-child visits	8.01%	6.78%	1.23%	18.14%
Well-Child 15 Month 17 (W1517) Two well-child visits	5.80%	5.15%	.065%	12.62%
Well-Child 15 Month 17 (W1517) Zero well-child visits	96.13%	94.04%	2.09%	2.22%

The following relevant measures have shown improvement towards meeting the 50th percentile, as indicated by a 10 percent or less *Gap to 50th percentile* target (see table below):

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Children and Adolescents' Access to Primary Care Practitioners*
- *Adolescent Well-Care Visits*
- *Childhood Immunization Status*
- *Chlamydia Screening in Women*
- *Prenatal and Postpartum Care*
- *Frequency of Ongoing Prenatal Care*
- *Follow-Up After Hospitalization for Mental Illness*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*

Table 5-14—HEDIS 2017 Measure Rate Performance

Measure	HEDIS 2017 Rate	50th Percentile Target	Gap to 50th Percentile Target
Adult Access 16 (AAP17) Total	74.57%	82.15%	7.58%
Childhood Immunization 17 (CS17) Combination 10 Immunizations	25.46%	32.64%	7.18%
Childhood Immunization 17 (CS17) Combination 6 Immunizations	32.89%	39.14%	6.25%
Childhood Immunization 17 (CS17) Combination 8 Immunizations	32.36%	38.20%	5.84%
Childhood Immunization 17 (CS17) Combination 9 Immunizations	25.99%	33.10%	7.11%
Children's Access 17 (CAP17) Members 12 to 19 Years of Age	79.79%	89.37%	9.58%
Children's Access 17 (CAP17) Members 12 to 24 Years of Age	89.95%	95.74%	5.79%
Chlamydia Screen 17 (CHL17) Total	53.06%	55.16%	2.10%
Follow-Up Hosp MH 17 (FUH17) Follow-Up within 30 days	61.17%	63.94%	2.77%
Follow-Up Hosp MH 17 (FUH17) Follow-Up within 7 days	37.80%	44.05%	6.25%
Freq Ongoing PNC 17 (FPC27) <21 percent of expected visits	14.60%	8.22%	-6.38%
Freq Ongoing PNC 17 (FPC27)—40 percent of expected visits	13.14%	5.82%	-7.32%

Measure	HEDIS 2017 Rate	50th Percentile Target	Gap to 50th Percentile Target
Freq Ongoing PNC 17 (FPC27)—60 percent of expected visits	11.92%	7.92%	-4.00%
Freq Ongoing PNC 17 (FPC27)—80 percent of expected visits	16.30%	14.95%	-1.35%
Initial Engagement AOD 17 (IET17) Engagement Total	10.79%	9.63%	-1.16%
Initial Engagement AOD 17 (IET17) Initiation Total	35.88%	38.07%	2.19%
Prenatal Post Care 17 (PPC27) Timeliness of prenatal care	76.40%	82.25%	5.85%
Well-Child 15 Month 17 (W1517) Five well-child visits	14.64%	16.49%	1.85%
Well-Child 15 Month 17 (W1517) Four well-child visits	9.94%	9.16%	-0.78%
Well-Child 15 Month 17 (W1517) One well-child visits	4.70%	1.95%	-2.75%
Well-Child 15 Month 17 (W1517) Six or more well-child visits	53.04%	59.57%	6.53%
Well-Child 15 Month 17 (W1517) Three well-child visits	8.01%	5.42%	-2.59%
Well-Child 15 Month 17 (W1517) Two well-child visits	5.80%	3.19%	-2.61%
Well-Child 15 Month 17 (W1517) Zero well-child visits	96.13%	98.29%	2.16%

2016 Non-ABD Population Recommendations

HSAG recommended that ‘Ohana QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
  - *Adults’ Access to Preventive/Ambulatory Health Services*
  - *Children and Adolescents’ Access to Primary Care Practitioners*
- Children’s Preventive Care
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/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*

  - *Chlamydia Screening in Women*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
  - *Controlling High Blood Pressure*
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
  - *Follow-Up After Hospitalization for Mental Illness*

Non-ABD Population Improvement Activities Implemented

'Ohana QI's Quality Improvement Intervention Workgroup (QIIW) and Quality Improvement (QI) Team HEDIS Focus Workgroup met regularly to review trending data for HEDIS measures, complete causal barrier analysis, and monitor status updates of interventions developed specifically to improve HEDIS rates. Smaller workgroups were developed to address specific HEDIS measures, such as behavioral health, women and children related measures. The following are improvement activities that were continued from 2016:

- 'Ohana QI continued to receive lab results directly from lab vendors Clinical Laboratories and Diagnostic Laboratory Services.
- HEDIS practice advisors (HPAs), currently known as Quality Practice Advisors (QPAs), conducted quality-focused provider visits. In partnership with the provider relations representatives (PR reps), providers received education and coaching on HEDIS measures and how to improve rates. The HPA and/or PR reps distributed HEDIS tool kits and care gap reports to providers and taught providers how to use the HEDIS online tool (via provider portal) as an additional method to look up members' care gaps and close care gaps by submitting medical records through the online tool.
- A pay-for-performance bonus program was offered to certain provider groups.
- During the 2017 HEDIS season, 'Ohana QI contracted approximately sixteen (16) temporary staff to collect medical record data and conduct over-reads used for HEDIS. 'Ohana QI also contracted an external vendor, Altegra, for the abstraction of medical records used for HEDIS for both Oahu and the neighbor islands. Six of the total temporary contracted staff were registered nurses (RNs) who focused mainly on inter-rater reliability (IRR) or over-reads of medical records. From this effort, 'Ohana QI exceeded its targeted 2017 goal from 85 percent to 96 percent of medical record retrieval.
- 'Ohana QI RNs conduct the annual medical record review (AMRR) audit and assess compliance with the plan's medical record standards and EPSDT documentation standards.
- Articles for both member and provider newsletters were published for the following: Chronic condition management, well-visits for children and adolescents, immunizations, women's health, prenatal and postpartum care, and behavioral health. 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 gap reports, and a scorecard was used to monitor the CCMA's progress in closing care gaps.
- A preventive care checklist that incorporated HEDIS-related preventive screenings was distributed to all members assigned to a service coordinator (SC). The reader-friendly checklist doubled 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 and disease management nurses discussed the checklist with members and instructed them to bring the checklist to their doctor's office during a follow-up visit for completion.
- Letters were mailed to providers to address members who have persistent asthma (based on claims data) and are on a controller medication. The letter included recommendations and a reminder to outreach the member to schedule a doctor's appointment.
- Mommy Baby Matters booklets, which included educational information on prenatal and postpartum care, were mailed out to pregnant members.
- Several outreach programs to educate members on chronic condition management and preventive screenings were completed. The following lists 'Ohana QI's various outreach programs:
  - The Centralized Telephonic Outreach program consisted of a vendor, Results, conducting calls to members with HEDIS care gaps and assisting them with scheduling an appointment with their physician and arranging transportation when needed.
  - The EPSDT coordinator and SCs outreached parents and guardians of pediatric members to educate and them assist with scheduling appointments for well-visits and to get their immunizations updated.
- The Service Coordinators 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 FUH care gaps.

2016 ABD Population Recommendations

HSAG recommended that 'Ohana QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the ABD population:

- Access to Care
  - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- Children's Preventive Care
  - *Adolescent Well-Care Visits*
  - *Immunizations for Adolescents*
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- Women's Health
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*

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  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness*
- Utilization and Health Plan Descriptive Information
  - *Ambulatory Care*

ABD Population Improvement Activities Implemented

The following are improvement activities that were continued in 2016:

- HPAs conducted quality-focused provider visits. In partnership with the PR reps, providers received education and coaching on HEDIS measures and how to improve rates. The HPA and/or PR reps distributed HEDIS tool kits and care gap reports to providers and taught providers how to use the HEDIS online tool (via provider portal) as an additional method to look up members care gaps and close care gaps by submitting medical records through the online tool.
- A pay-for-performance bonus program was offered to top-volume providers.
- During the 2017 HEDIS season, 'Ohana QI contracted approximately 16 temporary staff to collect data medical records and conduct over-reading of medical records used for HEDIS. 'Ohana QI also contracted an external vendor, Altegra, for the abstraction of medical records used for HEDIS for both Oahu and the neighbor islands. Six of the total temporary contracted staff were RNs who focused mainly on IRR or over-reads of medical records. From this effort, 'Ohana QI exceeded its targeted 2017 goal from 85 percent to 96 percent of medical record retrieval.
- 'Ohana QI contracted RNs to conduct the AMRR audit and assess compliance with the plan's medical record standards and EPSDT documentation standards.
- HPAs educated providers on the importance of chlamydia screening and collected medical records to enter into the pseudo claims supplemental database.
- Articles for both member and provider newsletters were published for the following: Chronic condition management, well-visits for children and adolescents, immunizations, women's health, prenatal and postpartum care, and behavioral health. Also, periodicity letters were mailed to members to remind them of preventive screenings and the importance of seeing their PCP.
- CCMAs were provided care gap reports, and a scorecard was used to monitor the CCMA's progress in closing care gaps.
- A preventive care checklist that incorporated HEDIS-related preventive screenings was distributed to all members assigned to an SC. The reader-friendly checklist doubled 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 and DM RNs discussed the checklist with members and instructed them to bring the checklist to their doctor's office during a follow-up visit for completion.
- Letters were mailed to providers to address members who have persistent asthma (based on claims data) and are on a controller medication. The letter included recommendations and a reminder to outreach the member to schedule a doctor's appointment.

- Mommy Baby Matters booklets, which included educational information on prenatal and postpartum care, were mailed out to pregnant members.
- Several outreach programs to educate members on chronic condition management and preventive screenings were completed. The following lists ‘Ohana QI’s various outreach programs:
  - The 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 and arranging transportation when needed.
  - The EPSDT coordinator and SCs outreached parents and guardians of pediatric members to educate and assist them with scheduling appointments for well-visits and to get their immunizations updated.
- The SCs addressed care gaps with members during their home visits or follow-up phone calls.

CAHPS—Adult Survey

2016 Recommendations

Based on an evaluation of ‘Ohana QI’s results, the priority areas identified were *Getting Needed Care*, *Customer Service*, and *Rating of Health Plan.*

Improvement Activities Implemented

Access to Care

The following quality improvement activities were conducted to address CAHPS findings in 2016:

- During 2016, ‘Ohana QI’s Community Advocacy department presented a total of 46 times on five islands. The presentations included topics such as fall prevention, diabetes, healthy eating, lowering blood pressure, depression, chronic kidney disease, nurturing gratitude, and more. In addition, the department attended 13 major health fairs on five islands. At these events, the department answered questions and distributed National Institutes of Health (NIH) and Substance Abuse and Mental Health Services Administration (SAMHSA) literature.
- Provider Relations representatives encouraged providers to adhere to appointment agenda letters that list individual preventive health measures. It is suggested these agendas are put in the patient’s chart as a reminder for the next appointment.
- SCs encouraged members to see their providers for needed care. They partnered with the patient, family members, and the medical provider to provide the most effective care plan for the member.

Customer Service

‘Ohana QI monitors call volume and hours of operation from its Kapolei office daily to ensure real-time accessibility. ‘Ohana QI also monitors the statistics on a weekly, monthly, quarterly, semi-annual, and annual basis to evaluate staffing, identify trends, and discuss opportunities for improvement. ‘Ohana QI’s call center is open during appropriate hours of operation based on customers’ needs. Members have

access to leave a non-urgent message after-hours as well. The call center can also provide assistance through social media, which includes a customer service handle on Twitter. 'Ohana QI has agents dedicated to log on every day and close out for the night. 'Ohana QI also has an on-call social media team to handle all after-hours inquiries. The health plan asks its members to complete a survey at the end of each call. These responses are part of each call center agent's performance goals. Content is reviewed as suggestions are made to provide a better member experience next time they call.

In an effort to ensure that new hires are adequately equipped to address member concerns, each new representative undergoes six weeks of new hire training in a classroom. Training is conducted by a dedicated training specialist. Training modules cover everything from soft skills and effective communication tools to HIPAA, cultural competency, Medicaid, and Medicare. Leadership staff members from across the organization are encouraged to come into the class and introduce topics to create a solid support structure. It also allows the agent to feel connected to the team while they are in training. The Step Up program has been deployed to assist new agents with the transition from the training environment to the production floor. The Step Up program is designed to supply agents who just finished training with a controlled environment in which they begin to take live calls. Agents are assisted by a supervisor or lead for a period of four weeks, at which time they are monitored and assisted where necessary. During these four weeks, agents receive daily quality audits that help them gauge their performance, and they must meet certain benchmarks to graduate from the program. The quality audits are conducted on same-day calls to provide real-time feedback and to discourage the development of bad habits. Along with quality audits, agents are provided with positive feedback for how they are performing and encouraged to improve through various exercises that they work through with the dedicated lead or supervisor.

Periodic refresher trainings are conducted to ensure that all agents are up to speed on any and all new processes and work flows and to ensure they are aware of all the different resources they have available to them so that they are well equipped to provide customers with the exceptional customer service. 'Ohana QI has also done training exercises to focus on effective written and verbal communication, which creates an overall better experience for the members.

Customer service focuses on various metrics, including Average Speed of Answer (ASA), Service Level (SL), Abandonment Rate (ABA), Average Handle Time (AHT), Customer Satisfaction Survey (CSAT), First Call Resolution (FCR), and Quality, to measure success. These performance measures are tracked month over month to ensure that regulatory call center metrics are met. When metrics are not met, root cause analysis is conducted and corrective action is taken. The Customer Service Performance measures are trended over the year and are included in the Quality Improvement Evaluation Report. Copies of the report are distributed to members of the Utilization Medical Advisory Board, which consists of external physicians.

A dedicated quality auditor was added to the staff, and daily scheduled quality audits are performed for all agents on a consistent basis. The number of audits conducted for each agent increased two-fold, and audits are conducted daily for calls serviced the day before to provide "real-time" performance scores and to identify areas of concern and to spotlight areas that were exceptional. If goals are not met, coaching takes place between the supervisor and agent using notes provided by the quality auditor.

Rating of Health Plan

The following quality improvement activities were conducted to address CAHPS findings in 2016:

- Telemedicine is an option where the provider can close gaps in patient care. Providers were encouraged to use this service as an alternative to face-to-face visits when appropriate.
- ‘Ohana QI recognizes the importance of a microsystem to effectively provide high-quality care to members and providers. ‘Ohana QI relies on its network of providers and their staff, as well as the health plan’s internal leadership, processes, and systems to be able to deliver services to members.
- A portion of ‘Ohana QI’s microsystem is its providers. ‘Ohana QI contracts with quality providers that serve members. The Provider Relations staff completed quarterly visits to provide training or answer questions about ‘Ohana QI or its processes. ‘Ohana QI routinely engaged providers in its operational processes through the quarterly Utilization Medical Advisory Committee (UMAC).
- In 2016, ‘Ohana QI continued its Members Matters Advisory Committee. This group brings together members and staff from the ‘Ohana QI team to discuss various topics. The focus is hearing about their experiences with ‘Ohana QI’s microsystem and how it might be improved.
- Metrics for ‘Ohana QI’s operations were measured in 2016 and reported to the quarterly Quality Improvement Committee (QIC), where ‘Ohana QI reviews, tracks, and trends regulatory reports that are submitted to the State, which include but are not limited to Member Grievances and Appeals, Provider Complaints, PCP Assignment, Geo Access, Timely Access, Translation and Interpretation, and Members Requesting Alternate Languages. Through these reports and many others, ‘Ohana QI can drive change effectively.
- ‘Ohana QI engaged members through interactive workshops, community events, and fairs. ‘Ohana QI held classes about members’ health conditions and how to improve their overall health. Sometimes, this included cooking classes for healthy eating. Additionally, ‘Ohana QI continuously engaged members through one-on-one education, mailers, and social media. Members who were assigned an SC were contacted regularly by the SC about issues regarding their health condition. During the visit or phone conversation, members were engaged about how to improve their condition and overall health. ‘Ohana QI’s educational mailers and social media sites showcased information about several health topics and how to improve overall medical and behavioral health. Educational mailers were sent to members with chronic conditions to enable members to maintain and improve their health.

Provider Survey

2016 Recommendations

The provider survey revealed opportunities to improve provider satisfaction. Based on these results, HSAG provided general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction.

- Providers consistently expressed concerns in getting adequate specialty care due to the lack of specialists. The process to refer patients to specialists was noted as especially difficult. The shortage of specialists on the island requires patients to travel to get care, but limitations related to availability and travel arrangements prevent many patients from being seen in a timely manner. Providers are becoming overwhelmed by the growing demand, while many members are being left with nowhere to go. HSAG recommends the QI health plans work with the MQD on a solution to this issue, such as provider recruitment and retention, and focus on the patient-centered medical home (PCMH) model of care.
- Some providers indicated that the prior authorization process has a negative impact on their ability to provide quality care. QI health plans could work toward programming medical services and drugs that require prior authorization into their systems and workflows to automate the process (e.g., expand availability and interoperability of health information technology). The QI health plans can work with the MQD to support the simplification and standardization of the preauthorization forms and process.
- Providers' feedback indicated that opportunities still exist to ensure that QI health plans have adequate access to non-formulary drugs. QI health plans typically choose which drugs to include in the formulary. The QI health plans should consider working with the MQD to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
- Periodic provider focus groups could be implemented to gain further valuable information and insight into areas of poor performance as described in the survey feedback. Hearing about specific scenarios and examples of provider issues may help the QI health plans in understanding and targeting areas needing performance improvement. QI health plans could then use a performance improvement project approach to determine interventions and perform a targeted remeasurement of provider satisfaction at a later date.

Improvement Activities Implemented

'Ohana QI implemented the following quality improvement activities:

- PR reps approached new providers in the community as well as non-participating (non-par) providers who frequently request authorizations to contract. Expansion of telehealth in 'Ohana QI's network allows broader coverage of members in the network.
- Some Medicare codes that formally needed authorizations are no longer required. Waiving authorizations for Medicaid is in process as well. Providers are encouraged to check the authorization look up tool for updates.
- The health plan's formulary is always available online on the 'Ohana QI website. Providers who refer members to non-formulary medications can fill out a drug evaluation form found on 'Ohana QI's website as well. Peer-to-peer consultation with 'Ohana QI's medical director is encouraged when appropriate.
- Feedback from provider surveys and face-to-face meetings is always welcome. Performance improvement suggestions are all considered and weighted.

HSAG HEALTH SERVICES ADVISORY GROUP

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2016 QI Population Recommendations

HSAG recommended that UHC CP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
  - *Children and Adolescents' Access to Primary Care Practitioners*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- 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*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*

QI Population Improvement Activities Implemented

UHC CP QI's quality improvement (QI) program takes a collaborative and multifaceted approach in engaging members in their care. The following interventions were implemented and are ongoing:

- For key HEDIS measures in 2017, UHC CP QI's clinical practice consultants (CPCs) worked with providers on identifying members who had gaps in care present and provided guidance on targeted initiatives, education, and strategies on engaging members.
- Provider quality conferences took place in Honolulu, Hilo, Kona, Waimea, and Kauai to address high-priority HEDIS measures.
- Directed education and training on HEDIS measures is scheduled to be provided to CCMAs to further engage UHC CP QI's adult foster homes and caregivers in October 2017.

- In early 2017, Advocate4Me was launched, which helped UHC CP QI's member services advocates engage members in addressing their care gaps when they call the health plan. Using Advocate4Me, member services advocates were able to help members schedule appointments with their providers beginning mid-2017.
- Inter-departmental training was provided to health plan staff on HEDIS measures through "Fast and Furious" training sessions.
- In July 2017, the Community Plan Primary Care Professional Incentive (CP PCPi) was implemented as an incentive program for Medicaid participating providers for addressing and closing gaps in care during visits.
- In mid-2017, UHC CP QI launched its Health Disparities Action Plan to improve *Adults' Access to Preventive/Ambulatory Health Services* (AAP) rates. While this measure was the primary focus of this particular action plan, the broader goal was for member engagement to cascade to other adult measures that need to be addressed as well when members attend their annual well-visit appointment.

The interventions above were implemented to address all key HEDIS measures, including those listed below. Some measures may have had additional interventions as noted below.

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
    - In 2017, UHC CP QI implemented its Health Disparities Action Plan, which focused on increasing AAP rates for members on the islands of Hawai'i, Maui, and Kauai, which were identified as having the most opportunities. Interventions as a part of the Health Disparities Action Plan included outreach via Silverlink interactive voice response (IVR), member education on PCP assignment and establishing care with a PCP before services are needed, using Advocate4Me to help members schedule appointments, providing a list of members who had not had an outpatient care appointment in 2017 to accountable care organization (ACO) partners for further member engagement, implementation of the CP PCPi program, and reinforcing timely access standards to providers.
  - *Children and Adolescents' Access to Primary Care Practitioners*
    - In 2017, UHC CP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits. A clinic day was scheduled for Q4 2017.
    - Throughout 2017, CPCs established and built relationships with pediatricians through engagement in the CP PCPi program.
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
    - An MRP [medication reconciliation post-discharge] stamp was developed and distributed to providers and CCMAs.
    - Partnered with the behavioral health team to provide training on BH conditions and the importance of medication management.
    - UHC CP QI CPCs provided education to providers throughout 2017.
    - UHC CP QI SCs provided education to their assigned members throughout 2017.

- 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*
    - In 2017, UHC CP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits and immunizations for adolescents. A clinic day was scheduled for Q4 2017.
    - Throughout 2017, CPCs established and built relationships with pediatricians through engagement in the CP PCPi program.
    - Initiated partnership with Pfizer VAKs (Vaccine Adherence in Kids) program in 2017. This is a reminder program for vaccinations, targeting parents of kids at 6 months, 8 months, and 16 months of age. Additionally, there is a well-visit reminder for the first-year checkup, targeting parents of children at 10 months of age to remind them of the need for their child's first well-visit doctor appointment.
    - Welltok/Silverlink live call outreach to address AWC, CIS, IMA, W15, and W34 occurred.
    - An EPSDT RN engaged the pediatric population with a variety of interventions, including reminder calls, birthday postcards, and collaborating with CPCs to provide education to providers on the importance of regularly scheduled well-visits and vaccines.
    - CPCs conducted focused education with providers on the AWC, CIS, W15, and W34 measures during Q1 of 2017.
- Women's Health
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
    - In 2017, UHC CP QI partnered with Waikiki Health to gather data on members who received a chlamydia screening at the health center for which a claim may not have been billed.
    - Throughout 2017, CPCs established and built relationships with obstetricians through engagement in the CP PCPi program.
    - CPCs conducted focused education with providers on the PPC and FPC measures during Q2 of 2017.
    - Continued partnership with the Hawaii State Department of Health to identify barriers regarding women's health.

2016 Non-ABD Population Recommendations

HSAG recommended that UHC CP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the non-ABD population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
  - *Children and Adolescents' Access to Primary Care Practitioners*
- 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
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
  - *Follow-Up After Hospitalization for Mental Illness*

Non-ABD Population Improvement Activities Implemented

In addition to the interventions listed in the section above that were implemented for all measures, the following additional interventions were implemented for the measures below:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services*
    - In 2017, UHC CP QI implemented its Health Disparities Action Plan, which focused on increasing AAP rates for members on the islands of Hawai'i, Maui, and Kauai, which were identified as having the most opportunities. Interventions as a part of the Health Disparities Action Plan included outreach via Silverlink interactive voice response (IVR), member education on PCP assignment and establishing care with a PCP before services are needed, using Advocate4Me to help members schedule appointments, providing a list of members

who had not had an outpatient care appointment in 2017 to accountable care organization (ACO) partners for further member engagement, implementation of the CP PCPi program, and reinforcing timely access standards to providers.

- *Children and Adolescents' Access to Primary Care Practitioners*
  - In 2017, UHC CP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits. A clinic day was scheduled for Q4 2017.
  - Throughout 2017, CPCs established and built relationships with pediatricians through engagement in the CP PCPi program.

- 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*
    - In 2017, UHC CP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits and immunizations for adolescents. A clinic day was scheduled for Q4 2017.
    - Throughout 2017, CPCs established and built relationships with pediatricians through engagement in the CP PCPi program.
    - Initiated partnership with Pfizer VAKs (Vaccine Adherence in Kids) program in 2017. This is a reminder program for vaccinations, targeting parents of kids at 6 months, 8 months, and 16 months of age. Additionally, there is a well-visit reminder for the first-year checkup, targeting parents of children at 10 months of age to remind them of the need for their child's first well-visit doctor appointment.
    - Welltok/Silverlink live call outreach to address AWC, CIS, IMA, W15, and W34 occurred.
    - An EPSDT RN engaged the pediatric population with a variety of interventions, including reminder calls, birthday postcards, and collaborating with CPCs to provide education to providers on the importance of regularly scheduled well-visits and vaccines.
    - CPCs conducted focused education with providers on the AWC, CIS, W15, and W34 measures during Q1 of 2017.

- Women's Health
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
  - *Human Papillomavirus Vaccine for Female Adolescents*
  - *Prenatal and Postpartum Care*
  - *Frequency of Ongoing Prenatal Care*
    - In 2017, UHC CP QI partnered with Waikiki Health to gather data on members who received a chlamydia screening at the health center for which a claim may not have been billed.

- Throughout 2017, CPCs established and built relationships with obstetricians through engagement in the CP PCPi program.
- During Q1 of 2017, CPCs conducted focused education with assigned providers and their office staff on the breast cancer screening measure.
- Continued partnership with the Hawaii State Department of Health to identify barriers regarding women's health.

- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
    - The CPCs conducted focused education with assigned providers and their office staff on the Comprehensive Diabetes measure during Q3 of 2017.
    - Welltok/Silverlink live call outreach to address CDC occurred in 2017.
- Behavioral Health
  - *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*
  - *Follow-Up After Hospitalization for Mental Illness*
    - In 2017, in collaboration with Quality, the behavioral health medical director and behavioral health team conducted three workshops on Oahu to educate providers on BH-specific HEDIS measures.

In addition, the behavioral health medical director facilitated five two-hour, face-to-face, and asynchronous trainings on psychotherapeutic medications in the community, which included free continuing education units to licensed clinical social workers and certified substance abuse counselors (CSACs). In all these trainings, the behavioral health medical director discussed the high morbidity of diabetes and other chronic medical conditions among adults with schizophrenia.

2016 ABD Population Recommendations

HSAG recommended that UHC CP QI focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the ABD population:

- Access to Care
  - *Children and Adolescents' Access to Primary Care Practitioners*
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
- Children's Preventive Care
  - *Immunizations for Adolescents*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*

- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*

ABD Population Improvement Activities Implemented

In addition to the interventions listed in the section above that were implemented for all measures, the following additional interventions were implemented for the measures below:

- Access to Care
  - *Children and Adolescents' Access to Primary Care Practitioners*
    - In 2017, UHC CP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits. A clinic day was scheduled for Q4 2017.
    - Throughout 2017, CPCs established and built relationships with pediatricians through engagement in the CP PCPi program.
- Effectiveness of Care
  - *Medication Reconciliation Post-Discharge*
    - An MRP stamp was developed and distributed to providers and CCMAs.
    - Partnered with the behavioral health team to provide training on BH conditions and the importance of medication management.
- Children's Preventive Care
  - *Immunizations for Adolescents*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
    - In 2017, UHC CP QI launched a partnership pilot with Ko'olauloa FQHC to address adolescent well-child visits and immunizations for adolescents. A clinic day was scheduled for Q4 2017.
    - Throughout 2017 CPCs established and built relationships with pediatricians through engagement in the CP PCPi program.
    - Welltok/Silverlink live call outreach to address IMA and W34 occurred.
    - An EPSDT RN engaged the pediatric population with a variety of interventions, including reminder calls, birthday postcards, and collaborating with CPCs to provide education to providers on the importance of regularly scheduled well-visits and vaccines.
    - CPCs conducted focused education with providers on AWC and W34 measures during Q1 of 2017.
- Women's Health
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women*
    - In 2017, UHC CP QI partnered with Waikiki Health to gather data on members who received a chlamydia screening at the health center for which a claim may not have been billed.
    - Continued partnership with the Hawaii State Department of Health to identify barriers regarding women's health.

- Care for Chronic Conditions
  - *Comprehensive Diabetes Care*
    - CPCs conducted focused education with assigned providers and their office staff on the *Comprehensive Diabetes Care* measure during Q3 of 2017.
    - Welltok/Silverlink live call outreach to address *Comprehensive Diabetes Care* occurred in 2017.

CAHPS—Adult Survey

2016 Recommendations

Based on an evaluation of UHC CP QI's results, the priority areas identified were *Getting Needed Care*, *Customer Service*, and *Getting Care Quickly.*

Improvement Activities Implemented

UHC CP QI addressed recommendations as follows:

Getting Needed Care

Interactive workshops: Throughout 2017, UHC CP QI participated in 51 community engagement initiatives. During these events UHC CP QI provided education to the public on the following topics (not limited to):

- The importance of healthy eating and regular exercise
- Blood pressure
- Heart disease and stroke
- Diabetes management and prevention
- Asthma management
- Smoking cessation
- Water consumption
- The importance of prenatal and postpartum care
- Information on preventive health care for children and adolescents and EPSDT
- Dr. Health E Hound's Healthy Tips for Parents
- Healthy recipe cards
- Using the UHC NurseLine™ through active engagement, activities, and educational materials

In addition to active engagement, UHC CP QI regularly sent annual EPSDT appointment reminders to its youth population, and mailers to members in the diabetes, asthma, and high-risk pregnancy disease

management programs, amongst other topics. UHC CP QI also conducted a quarterly Member Advisory Group (MAG) to provide education to a targeted member focus group and solicit feedback.

Facilitate coordinated care: UHC CP QI service coordination teams assisted in facilitating coordination of care between providers by way of providing service plans on initial entry into service coordination, and reassessments. Service coordinators also completed provider outreach for coordination of care and to provide/obtain additional information to/from providers that will assist in members' healthcare needs. UHC CP QI had a process in place to ensure that PCPs regularly receive updates to members' service plans through fax or mail. In addition, UHC CP QI further supported providers in service coordination by creating a Service Coordination Form and ensuring availability of form in all channels (e.g., provider education materials, provider website, etc.). In 2017, UHC CP QI also implemented a hotline to the Service Coordination department for providers. UHC CP QI collaborated with its ACO partners by starting a Joint Operating Committee (JOC) that included care coordination. In addition, for facilities, UHC CP QI implemented fast-track availability of the service coordination team to facility ERs and case managers to ensure timely coordination.

Customer Service

Call centers and user feedback: In 2017, UHC CP QI reengineered the User Experience Survey (UES) to gain better insight on the user experience when contacting the call center. Results of the UES were reviewed on a regular basis to address opportunities for improvement. In addition, UHC CP QI partnered with Eliza to gather more specific data on members' feelings and needs as it relates to CAHPS and target future interventions. UHC CP QI also conducted a quarterly MAG to solicit feedback on the member experience from a small panel of members. These meetings took place on either Oahu or the neighbor islands throughout the year to gather data from various perspectives.

Creating an effective customer service training program: In 2017, collaborative training took place with the call center staff and multiple departments including Quality and Behavioral Health. member services advocates received training on quality initiatives and HEDIS measures through Fast and Furious training. In addition, the implementation of the Advocate4Me program in April 2017 set out to provide a more positive experience for members by providing Member Services staff with more detailed information about members and their healthcare needs. All Member Services staff received training on the new program. In addition, active listening training was conducted for all member-facing staff, including Member Services, in collaboration with the Behavioral Health department.

Customer Service Performance Measures

Throughout 2017, Member Services was assessed on a variety of metrics for both State and NCQA compliance. The data were obtained from the Member Services call center monthly call statistics from the. The results evaluated monthly include Average Calls Offers (ACO), Average Calls Handled (ACH), Abandonment Rate (ABN) percentage, Average Speed of Answer (ASA), and Service Level. A goal of Service Level Rate in 30 Seconds was established at 80 percent and was met in all three quarters to date.

Getting Care Quickly

Patient access and availability: Throughout 2017, UHC CP QI monitored provider availability through both the PCP and High Volume Specialist (HVS) and High Impact Specialist (HIS) reports through both numerical availability ratios per county and per island, as well as through GeoAccess, as recommended. In addition, the Timely Access Report Survey was conducted quarterly in 2017 and alternated between surveying both providers and members to gather accurate data of the member experience. The top 10 providers by volume who had missed targets during 2017 were engaged in additional education and training on the importance of meeting timely access standards. In addition, this education is provided at least annually to providers through education sessions or provider materials.

Decrease no-show appointments: In 2017, UHC CP QI partnered with its transportation provider, LogistiCare, to gather data on members prone to no-show for transportation. A monthly roster of members who failed to show up for transportation, and subsequently their appointments, was shared with UHC CP QI service coordinators and behavioral health advocates to conduct follow-up with members and engage them in their care. UHC CP QI solicited feedback from the Member Advisory Group on no-shows, how to decrease them, and the barriers that members may be facing leading to them not keeping appointments.

Provider Survey

2016 Recommendations

The provider survey revealed opportunities to improve provider satisfaction. Based on these results, HSAG provided general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction

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

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

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

Improvement Activities Implemented

UHC CP QI addressed recommendations as follows:

Providers and Specialty Care Access

Travel improvements: In 2017, the UHC CP QI Operations Team implemented face-to-face meetings with the Hawaii LogistiCare manager at least weekly to address issues such as late provider pickups, member-cancelled trips, coordination of commercial air travel, and to troubleshoot other issues. UHC CP QI also reviewed provider geographic assignments to ensure they were appropriate. UHC CP QI coordinated with the prior authorization team to ensure that if healthcare services require urgent transportation, they are escalated to LogistiCare management immediately for scheduling. UHC CP QI offered mileage reimbursement for mammogram services on the island of Hawai'i due to the only radiology center in Hilo temporarily not having their mammography certificate re-approved by the State of Hawaii Department of Health in order to aid members in obtaining transportation for mammograms. LogistiCare initiated a user satisfaction survey to obtain feedback on services. In addition, LogistiCare was scheduled to add two wheelchair providers and one gurney provider in Q4 2017 and is consistently expanding its network (e.g., using Lyft for recovery when a transport provider's vehicle becomes inoperable during a trip).

Provider recruitment and retention: The UHC CP QI Network team continued to work with providers to increase service levels for high-touch providers to promote retention and continue to look for opportunities to expand tele-health services to deliver additional specialty care.

Focus on the PCMH model of care: In 2017, UHC CP QI transitioned from its person-centered care model (PCCM) to the whole person care (WPC) model of care. Medical, behavioral, and social/environmental concerns were targeted by engagement of members, hospitals, and physicians working together. The primary goal is to ensure the member receives the right care from the right providers in the right place and at the right time. At a member level, this WPC program targets those individuals who have a higher persistency of healthcare utilization and may have chronic and complex emerging risk. The goal is to focus interventions on members with complex medical, behavioral, social, pharmacy, and specialty needs, which results in better quality of life for members, improved access to healthcare, and reducing expenses. The WPC program assesses the member and provides an integrated team for the member with the goal of increasing member engagement in the healthcare process, providing resources to fill gaps in care, and developing individualized goals toward a common outcome using evidence-based clinical guidelines. Improving the care experience and member outcomes guides

UHC CP QI's commitment to whole person care, essential to improving the health and wellbeing of individuals, families, and communities. Through the WPC model, UHC CP QI engages with PCPs, other healthcare professionals, and key partners to expand access to quality healthcare so members can get the care they need when they need it. UHC CP QI supports the physician/patient relationship by removing barriers to care and ensuring members see their physicians on a regular basis. UHC CP QI empowers members by providing the information, guidance, and tools they need to make informed personal healthcare decisions.

Simplification and standardization of PA forms and processes: In 2016 through 2017, the Pharmacy and Therapeutics Committee added 91 new drugs to the preferred drug list (PDL); 56 of them became available as preferred open access (no prior authorization required), and 35 of them became available preferred requiring prior authorization.

Pharmacy access and standard operating procedures and policies and procedures related to non-formulary drugs: UHC CP QI updated its product selection criteria and provided prescribers with guidance on non-PDL medications, as well as policies and procedures on obtaining non-PDL medications with a seven-day or 15-day supply override when there is a need for a new non-PDL medication and a prior authorization has not yet been received through the UHC CP QI health professionals website.

Provider focus groups: At least quarterly, UHC CP QI obtained feedback from its Physician Advisory Committee (PAC). Topics discussed at PAC included (but were not limited to) provider access concerns and recommendations; provider recruitment and retention, and evaluation of their experiences with the contracting and credentialing practices; feedback on the prior-authorization processes; and quarterly review of PDL updates and revisions. In addition, the annual Provider Satisfaction Survey and CAHPS results were reviewed and recommendations for improvement were solicited from PAC members. In addition to the in-person focus group, 2017 saw greater engagement, with review of UHC CP QI's provider Net Promoter Score (NPS) results and implementation of a subsequent NPS action plan.

‘Ohana Community Care Services (‘Ohana CCS)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2016 Recommendations

HSAG recommended that ‘Ohana CCS focus on improving performance related to the following measures with rates that fell below the national Medicaid 25th percentile for the CCS program:

- Behavioral Health
  - *Diabetes Monitoring for People with Diabetes and Schizophrenia*
  - *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Improvement Activities Implemented

The following improvement activities were implemented or continued in 2016:

- ‘Ohana CCS continued to work with other health plans to receive file information for HEDIS measures that are based on medical services. The BH/CCS case management agencies receive ongoing education on HEDIS measures.
- Field coordination, CCS care managers and other ‘Ohana CCS staff received training on serious mental illness (SMI) and diabetes to develop an understanding of the relationship between diabetes symptomology, pharmaceuticals, and serious mental health diagnoses.
- ‘Ohana CCS case management agencies received provider education on Oahu (October 2016) and Maui (August 2016) and in Hilo (July 2016), which included the above performance measures as well as other BH-specific HEDIS measures.
- ‘Ohana CCS agency providers participated in a quality improvement-focused meeting in 2016, which addressed interventions for HEDIS measures, including the above quality measures.

In addition, a shared consent form was created and is currently being reviewed for approval for use in 2017. If approved, the form will be used between PCPs and psychiatrists/other specialists involved in member care to allow providers to collaborate on members’ diabetes screening and monitoring for those members with schizophrenia or bipolar disorders who are using antipsychotic medications.

Appendix A. Methodologies for Conducting EQR Activities

Introduction

In calendar year (CY) 2017, HSAG, as the EQRO for the MQD, conducted the following EQR activities for the QI health plans and CCS program in accordance with applicable CMS protocols:

- A review of compliance with federal and State requirements for select standard areas and a follow-up reevaluation of compliance following implementation of 2016 CAPs
- Validation of performance measures (i.e., NCQA HEDIS Compliance Audits)
- Validation of PIPs
- A survey of child Medicaid members using the CAHPS survey
- A survey of a statewide sample of CHIP members using the child Medicaid CAHPS survey

For each EQR activity conducted in 2017, 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

2017 Compliance Monitoring Review

Objectives

The Balanced Budget Act of 1997 (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 health plans and the CCS program health plan. For the 2017 EQR compliance monitoring activity, the second year of MQD's three-year cycle of compliance review activities, HSAG conducted a desk audit and an on-site review of the health plans to assess the degree to which they met federal managed care and State requirements in select standard areas. The primary objective of HSAG's 2017 review was to provide meaningful information to the MQD and the QI and CCS health plans regarding contract compliance with those standards.

The following six standards were assessed for compliance:

- Standard I Provider Selection
- Standard II Subcontracts and Delegation
- Standard III Credentialing
- Standard IV Quality Assessment and Performance Improvement
- Standard V Health Information Systems
- Standard VI Practice Guidelines

The findings from the desk audit and the on-site review were intended to provide the MQD, the QI health plans, and the CCS program with a performance assessment and, when indicated, recommendations to be used to:

- Evaluate the quality and timeliness of, and access to, care furnished by the health plan.
- Monitor interventions that were implemented for improvement.
- Evaluate each health plan's current structure, operations, and performance on key processes.
- Initiate targeted activities to ensure compliance or enhance current performance, as needed.
- Plan and provide technical assistance in areas noted to have substandard performance.

Once each of the health plans' final compliance review reports 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 QI 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]

[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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: March 1, 2018.

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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 the health plans and 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 period). HSAG also obtained information for the compliance monitoring review through observation during the on-site review and through interaction, discussion, and interviews with key health plan staff members.

At the conclusion of each compliance review, HSAG provided the health plan and the MQD with a report of findings and any required corrective actions. The plan-specific results are summarized in Section 3 of this report.

Validation of Performance Measures—HEDIS Compliance Audits

Objectives

As set forth in 42 CFR §438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

The following table presents the State-selected performance measures and required methodology for the 2017 validation activities. Note that several measures' technical specifications were State-defined, non-HEDIS measures. Both HEDIS and non-HEDIS measures were validated using the same methodology, which is described in further detail in the following section.

Table A-1—Validated Performance Measures

Performance Measure	QI	CCS	Methodology
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services	✓		Admin
Children and Adolescents' Access to Primary Care Practitioners	✓		Admin
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	Admin

Performance Measure	QI	CCS	Methodology
Children's Preventive Care			
Adolescent Well-Care Visits	✓		Hybrid^
Childhood Immunization Status	✓		Hybrid^
Immunizations for Adolescents	✓		Hybrid^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		Hybrid
Well-Child Visits in the First 15 Months of Life	✓		Hybrid^
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	✓		Hybrid^
Women's Health			
Breast Cancer Screening	✓		Admin
Cervical Cancer Screening	✓		Hybrid^
Chlamydia Screening in Women	✓		Admin
Frequency of Ongoing Prenatal Care	✓		Hybrid
Prenatal and Postpartum Care	✓		Hybrid
Care for Chronic Conditions			
Annual Monitoring for Patients on Persistent Medications	✓		Admin
Comprehensive Diabetes Care	✓		Hybrid^
Controlling High Blood Pressure	✓		Hybrid
Medication Management for People With Asthma	✓		Admin
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		✓	Admin
Antidepressant Medication Management	✓	✓	Admin
*Behavioral Health Assessment***		✓	Hybrid
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	✓		Admin
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		Admin
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	✓	✓	Admin
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	Admin
Follow-Up After Hospitalization for Mental Illness	✓	✓	Admin
Follow-Up Care for Children Prescribed ADHD Medication	✓		Admin
*Follow-Up With Assigned PCP Following Hospitalization for Mental Illness***	✓		Admin

Performance Measure	QI	CCS	Methodology
Utilization and Health Plan Descriptive Information			
Ambulatory Care—Total	✓	✓	Admin
Enrollment by Product Line—Total	✓	✓	Admin
Inpatient Utilization—General Hospital/Acute Care—Total	✓		Admin
Mental Health Utilization—Total	✓	✓	Admin
Plan All-Cause Readmissions	✓		Admin

** Indicates this measure is a State-specified, non-HEDIS measure.

^ KFHP QI received approval from the MQD to report seven measures via the administrative methodology. These measures were *Adolescent Well-Care Visits*; *Childhood Immunization Status*; *Immunizations for Adolescents*; *Cervical Cancer Screening; Comprehensive Diabetes Care* (except the *Comprehensive Diabetes Care—Blood Pressure Control [<140/90 mm Hg]*, *Medical Attention for Nephropathy*, and *Eye Exam [Retinal] Performed* indicators, which were reported using hybrid methodology); *Well-Child Visits in the First 15 Months of Life;* and *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*. HMSA reported the *Comprehensive Diabetes Care—HbA1c Control (<7.0%)* measure via administrative methodology as well.

Technical Methods of Data Collection and Analysis

HSAG validated the performance measures calculated by health plans for the QI population and CCS using selected methodologies presented in *HEDIS 2017, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.* The measurement period reviewed for the health plans was CY 2016 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.

The measures verified by the HSAG review team received an audit result consistent with one of the seven NCQA categories listed in the following table.

Table A-2—NCQA Audit Results

NCQA Category for Measure Audit Result	Comment
R	*Reportable.* A reportable rate was submitted for the measure.
NA	*Small Denominator.* The health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB	*No Benefit.* The health plan did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reported.* The health plan chose not to report the measure.
NQ	*Not Required.* The health plan was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The health plan chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., measures collected using electronic clinical data systems).

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 *HEDIS 2017, 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 and compared to the MQD Quality Strategy targets in Section 3 of this report; and in Section 4, a comparison of all plans' results is provided, along with an overall comparison of the MQD Quality Strategy targets.

Also presented in this report are the actual HEDIS and non-HEDIS performance measure rates reported by each health plan on the required performance measures validated by HSAG with comparisons to the NCQA national Medicaid HEDIS 2016 Audits Means and Percentiles and to the previous year's rates, where applicable. Measure rates reported by the health plans, but not audited by HSAG in 2017, 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, the HEDIS 2016 rate, percentage point change, and 2017 performance level values are denoted with a double-dash (--) within the tables for these measures.

The health plan results tables show the current year's performance for each measure compared to the prior year's rate and the performance level relative to the NCQA national Medicaid HEDIS 2016 percentiles, where applicable. The performance level column illustrated in the tables rates the health plans' performance as follows:

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

In the results tables, rates shaded green with one caret (^) indicate a statistically significant improvement in performance from the previous year. Rates shaded red with two carets (^^) indicate a statistically significant decline in performance from the previous year. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05. Additionally, rates shaded yellow with one cross ($^{+}$) indicate that the rate met or exceeded the MQD Quality Strategy target. The MQD Quality Strategy targets are defined in Table A-3.

Table A-3—MQD Quality Strategy Measures and Targets

Performance Measure	MQD Quality Strategy Target[1]
Access to Care	
Children's Preventive Care	
Childhood Immunization Status[2]	75th Percentile
Women's Health	
Breast Cancer Screening	75th Percentile
Cervical Cancer Screening	75th Percentile
Frequency of Ongoing Prenatal Care	75th Percentile
Prenatal and Postpartum Care—Timeliness of Prenatal Care	75th Percentile
Care for Chronic Conditions	
Comprehensive Diabetes Care[3]	75th Percentile/50th Percentile
Controlling High Blood Pressure	75th Percentile
Medication Management for People With Asthma	75th Percentile
Behavioral Health	
Follow-Up After Hospitalization for Mental Illness	75th Percentile

Performance Measure	MQD Quality Strategy Target[1]
Utilization and Health Plan Descriptive Information	
Ambulatory Care—Total[4]	90th Percentile

[1] The MQD Quality Strategy targets are based on NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2016.

[2] For this measure, an MQD Quality Strategy target was established only for the *Childhood Immunization Status—Combination 2* measure indicator.

[3] For this measure, MQD Quality Strategy targets were established only for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* measure indicators. The *HbA1c Testing*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)* measure indicators were assessed compared to the national Medicaid 75th percentile, and the *HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)* measure indicators were assessed compared to the national Medicaid 50th percentile as part of the MQD Quality Strategy.

[4] For this measure, an MQD Quality Strategy target was established only for the *Ambulatory Care—Emergency Department Visits per 1,000 Member Months* measure indicator. The MQD defined the national Medicaid 10th percentile as the Quality Strategy target; however, because HSAG reversed the order of the national Medicaid percentiles for this measure since a lower rate indicates better performance, this measure was assessed compared to the national Medicaid 90th percentile as part of the MQD Quality Strategy.

For the following measures, a lower rate indicates better performance: *Well-Child Visits in the First 15 Months of Life—Zero Visits, Frequency of Prenatal Care—<21 Percent of Expected Visits, Ambulatory Care—Emergency Department Visits per 1,000 Member Months,* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*. For example, the national Medicaid 25th percentile (a lower rate) was reversed to become the national Medicaid 75th percentile, indicating better performance.

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 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 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]

[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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Feb 19, 2018.

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 2017, HSAG concluded validation activities on 12 PIPs submitted by the Hawaii Medicaid health plans, as described in the following table:

Table A-4—2017 Validated PIPs

Health Plan	PIP Topic
AlohaCare QI	1. *All-Cause Readmissions* 2. *Diabetes Care*
HMSA QI	1. *All-Cause Readmissions* 2. *Diabetes Care*
KFHP QI	1. *All-Cause Readmissions* 2. *Diabetes Care*
‘Ohana QI	1. *All-Cause Readmissions* 2. *Diabetes Care*
UHC CP QI	1. *All-Cause Readmissions* 2. *Diabetes Care*
‘Ohana 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 noted that all 12 PIPs continued to provide opportunities for the health plans to improve the quality of care for their members.

Additionally, in 2017 HSAG initiated validation activities for 12 new PIPs to be submitted by the Hawaii Medicaid health plans, as described in the following table:

Table A-5—New PIP Topics Initiated in 2017

Health Plan	PIP Topic
AlohaCare QI	1. *Prenatal and Postpartum Care* 2. *Getting Needed Care*
HMSA QI	1. *Prenatal and Postpartum Care* 2. *Getting Needed Care*
KFHP QI	1. *Medication Management for People with Asthma (Ages 5-64)* 2. *Getting Needed Care*

Health Plan	PIP Topic
‘Ohana QI	1. *Prenatal and Postpartum Care* 2. *Getting Needed Care*
UHC CP QI	1. *Prenatal and Postpartum Care* 2. *Getting Needed Care*
‘Ohana CCS	1. *Follow-Up After Hospitalization for Mental Illness (7 Days)* 2. *Behavioral Health Assessment*

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 2017 validation cycle.

PIP Components and Process

HSAG, along with some of its contracted states, has identified that, while 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 methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement.

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To illustrate how the rapid-cycle PIP framework continued to meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG presented the crosswalk and new PIP framework components to CMS, and CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within healthcare settings, a new approach was reasonable, approving HSAG's rapid-cycle PIP framework for validation of PIPs for the State of Hawaii.

The key concepts of the 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 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.

For this PIP framework, HSAG developed five modules with an accompanying 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 mode 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 thoughtful and incremental PDSA cycles.
- Module 5—PIP Conclusions: Module 5 summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

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.

Each module consists of validation criteria necessary for successful completion of a valid PIP. Each evaluation element is scored as either Achieved or Not Achieved. 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 Aim measure, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- *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.
- *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.

Training

HSAG continued to provide guidance, training, and oversight of the PIPs during the current validation cycle. HSAG has been involved from the onset of the PIPs to determine their methodological soundness and to ensure the health plans have the knowledge and guidance needed to be successful, not only in documentation of their approach but also in the application of the rapid-cycle quality improvement methods that are central to achieving improved outcomes. HSAG provided written feedback to the health plans after each module was completed and submitted for review. HSAG also offered technical assistance phone conferences to each health plan to provide further clarification on the recommendations for each module. HSAG's rapid-cycle PIP validation process facilitated frequent technical assistance for the health plans throughout the process, as requested.

In May 2016, HSAG trained the health plans on the Module 4 submission requirements. In March 2017, after the initial Module 4 and Module 5 submissions, HSAG provided a Module 1 through 5 retraining and included information related to the new PIP topics that the health plans will submit for validation in June 2017.

2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey

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 and the CHIP 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, 2016. 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 QI health plan members the option to complete the CAHPS survey in the designated alternate languages (i.e., Chinese, Ilocano, Korean, and Vietnamese).

The Child CAHPS survey included a set of standardized items (48 questions) that assessed parents'/caretakers' perspectives on their child'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 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 (+).

[A-3] National Committee for Quality Assurance. *HEDIS 2017*, *Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2016.

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*).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction rating (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate. In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (i.e., 1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite measure 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 composite measures 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*).[A-4] 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 *Coordination of Care* 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 published NCQA Benchmarks and Thresholds to derive the overall member satisfaction rating (i.e., star rating), except for the *Shared Decision Making* composite measure and the *Health Promotion and Education* individual item.[A-5] 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

[A-4] Three-point means are not calculated for the *Shared Decision Making* composite measure.

[A-5] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017.* Washington, DC: NCQA, May 4, 2017.

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

For purposes of the Statewide Comparisons analysis, HSAG calculated question summary rates for each global rating and individual item measure, and global proportions for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.[A-6] Additionally, HSAG performed a trend analysis of the child and CHIP results. For the 2017 Child CAHPS scores, scores were compared to their corresponding 2015 CAHPS scores to determine whether there were statistically significant differences, while CHIP 2017 CAHPS scores were compared to their corresponding 2016 CAHPS scores. A *t* test was performed to determine whether results in 2017 were statistically significantly different from results in 2015. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than or equal to 0.05. The two-sided *p* value of the *t* test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance. Scores that were statistically significantly higher in 2017 than in 2015 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2017 than in 2015 are noted with black downward (▼) triangles. Scores in 2017 that were not statistically significantly different from scores in 2015 are not noted with triangles. In addition to the trend analysis, results were compared to NCQA national averages.[A-7,A-8] These comparisons were performed for the four global ratings, five composite measures, and two individual item measures.

Description of Data Obtained

The CAHPS survey asks members or parents or caretakers to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The surveys were administered from

[A-6] National Committee for Quality Assurance. HEDIS 2017, Volume 3: Specifications for Survey Measures. Washington, DC: NCQA Publication, 2016.

[A-7] NCQA national averages for 2017 were not available at the time this report was prepared; therefore, 2016 NCQA national averages are presented in this section.

[A-8] For the NCQA national child Medicaid averages, the source for data contained in this publication is Quality Compass 2016 data and is used with the permission of NCQA. Quality Compass 2016 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

February to April 2017 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 three of the designated five questions were completed.[A-9] Eligible members included the entire sample minus ineligible members. Ineligible child members met at least one of the following criteria: they were deceased, were invalid (did not meet the eligible population criteria), or 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 CAHPS surveys, HSAG provided the MQD with a plan-specific report of findings and a statewide aggregate report. The MQD also received a statewide aggregate report of the CHIP survey results.

The plan-specific results of the Child CAHPS survey and the CHIP results of the Child CAHPS survey are summarized in Section 3 of this report. A statewide comparison of each adult Medicaid QI health plan and the QI Program aggregate results, as well as the CHIP population results, are provided in Section 4.

[A-9] A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed: questions 3, 15, 27, 31, and 36.