State of Hawaii

Department of Human Services

Med-QUEST Division

# 2018 External Quality Review Report of Results

*for the*

# QUEST Integration Health Plans

and the

# Community Care Services Program

*April 2019*

HSAG HEALTH SERVICES ADVISORY GROUP

# Contents


**1. Executive Summary ..... 1-1**
Overview ..... 1-1
Purpose of the Report ..... 1-1
Scope of EQR Activities ..... 1-2
Overall Summary of Health Plan Performance ..... 1-3
Compliance Monitoring Review ..... 1-3
Validation of Performance Measures—NCQA HEDIS Compliance Audits ..... 1-4
Performance Improvement Projects ..... 1-7
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Plan-Specific Adult Medicaid Survey and Statewide CHIP Survey ..... 1-10
Provider Survey ..... 1-13

**2. Introduction ..... 2-1**
Purpose of the Report ..... 2-1
Quality Strategy Annual Assessment ..... 2-2
Compliance Reviews ..... 2-2
Performance Measures ..... 2-2
Performance Improvement Projects ..... 2-2
Consumer Surveys ..... 2-3
Technical Assistance ..... 2-3
Summary of Report Content ..... 2-3
Overview of the Hawaii Medicaid Service Delivery System ..... 2-4
The Hawaii Medicaid Program ..... 2-4
The QUEST Integration Health Plans ..... 2-6
The State's Quality Strategy ..... 2-7

**3. Assessment of Health Plan Performance ..... 3-1**
Introduction ..... 3-1
Methodology ..... 3-1
AlohaCare QUEST Integration (AlohaCare QI) Results ..... 3-2
Compliance Monitoring Review ..... 3-2
Validation of Performance Measures—NCQA HEDIS Compliance Audits ..... 3-3
Validation of Performance Improvement Projects ..... 3-13
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey ..... 3-15
Provider Survey ..... 3-18
Overall Assessment of Quality, Access, and Timeliness of Care ..... 3-20
Hawaii Medical Service Association QUEST Integration (HMSA QI) Results ..... 3-22
Compliance Monitoring Review ..... 3-22
Validation of Performance Measures—NCQA HEDIS Compliance Audits ..... 3-23
Validation of Performance Improvement Projects ..... 3-32
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey ..... 3-35

Provider Survey ..... 3-38
Overall Assessment of Quality, Access, and Timeliness of Care ..... 3-39
Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results ..... 3-41
Compliance Monitoring Review ..... 3-41
Validation of Performance Measures—NCQA HEDIS Compliance Audits ..... 3-42
Validation of Performance Improvement Projects ..... 3-50
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey ..... 3-52
Provider Survey ..... 3-55
Overall Assessment of Quality, Access, and Timeliness of Care ..... 3-57
'Ohana Health Plan QUEST Integration ('Ohana QI) Results ..... 3-59
Compliance Monitoring Review ..... 3-59
Validation of Performance Measures—NCQA HEDIS Compliance Audits ..... 3-60
Validation of Performance Improvement Projects ..... 3-69
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey ..... 3-71
Provider Survey ..... 3-74
Overall Assessment of Quality, Access, and Timeliness of Care ..... 3-75
UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results ..... 3-77
Compliance Monitoring Review ..... 3-77
Validation of Performance Measures—NCQA HEDIS Compliance Audits ..... 3-78
Validation of Performance Improvement Projects ..... 3-87
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey ..... 3-89
Provider Survey ..... 3-92
Overall Assessment of Quality, Access, and Timeliness of Care ..... 3-93
'Ohana Community Care Services ('Ohana CCS) Results ..... 3-95
Compliance Monitoring Review ..... 3-95
Validation of Performance Measures—NCQA HEDIS Compliance Audits ..... 3-96
Validation of Performance Improvement Projects ..... 3-100
Overall Assessment of Quality, Access, and Timeliness of Care ..... 3-102

**4. Comparative Analysis of Health Plan Performance ..... 4-1**
Introduction ..... 4-1
Compliance Monitoring Review ..... 4-1
Validation of Performance Measures—HEDIS Compliance Audits ..... 4-2
NCQA HEDIS Compliance Audits ..... 4-2
HEDIS Performance Measure Results ..... 4-2
Summary of MQD Quality Strategy Targets ..... 4-12
Validation of Performance Improvement Projects ..... 4-13
Consumer Assessment of Healthcare Providers and Systems (CAHPS) ..... 4-14
Statewide Comparisons—QI Health Plans ..... 4-14
National Average Comparisons—Children's Health Insurance Program (CHIP) ..... 4-16
NCQA Comparisons—QI Health Plans ..... 4-16
NCQA Comparisons—CHIP ..... 4-19
Provider Survey ..... 4-20
Plan Comparisons ..... 4-20

Trend Analysis ..... 4-21

**5. Assessment of Follow-up to Prior Year Recommendations ..... 5-1**

Introduction ..... 5-1
Compliance Monitoring Review ..... 5-1
Performance Improvement Projects ..... 5-1
AlohaCare Quest Integration (AlohaCare QI) ..... 5-2
Validation of Performance Measures ..... 5-2
CAHPS—Adult Survey ..... 5-8
HMSA Quest Integration (HMSA QI) ..... 5-11
Validation of Performance Measures ..... 5-11
CAHPS—Adult Survey ..... 5-13
Kaiser Foundation Health Plan QUEST Integration (KFHP QI) ..... 5-15
Validation of Performance Measures ..... 5-15
CAHPS—Adult Survey ..... 5-17
'Ohana Health Plan QUEST Integration ('Ohana QI) ..... 5-18
Validation of Performance Measures ..... 5-18
CAHPS—Adult Survey ..... 5-20
UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) ..... 5-22
Validation of Performance Measures ..... 5-22
CAHPS—Adult Survey ..... 5-26
'Ohana Health Plan Community Care Services ('Ohana CCS) ..... 5-29
Validation of Performance Measures ..... 5-29

**Appendix A. Methodologies for Conducting EQR Activities ..... A-1**

# 1. Executive Summary

## Overview

The 2018 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 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 CFR 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.
- A description of the scope of EQR activities performed by HSAG.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016/Rules and Regulations. 42 CFR Parts 431, 433 and 438 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.

[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, 2019.

- 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 survey.
- Recommendations for the health plans to improve members' 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 conducted follow-up monitoring of the health plans that were required to take corrective actions related to findings from HSAG's 2017 compliance review.
- *Validation of PIPs*. HSAG validated PIPs to ensure the health plans designed, conducted, and reported the projects in a methodologically sound manner consistent with the CMS protocols for PIPs. Each health plan submitted two state-mandated PIPs for validation. The PIPs are conducted using HSAG's rapid-cycle approach, which includes five modules that are submitted by the health plans as the PIP progresses. HSAG validates the module submissions and provides feedback to the health plans throughout the PIP. The health plans started new rapid-cycle PIP topics in 2017 and were focused on completion of Modules 1 through 3. The PIP timeline specified that health plans should test interventions until December 31, 2018, and following, complete the final analysis in Modules 4 and 5. HSAG will validate the PIP outcome results in February 2019.
- *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 2018 through July 2018. The final PM validation results generally reflect the measurement period of January 1, 2017, through December 31, 2017. HSAG provided final audit reports to the health plans and the MQD in July 2018.
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys*.[1-5] The MQD conducted CAHPS surveys of the adult QI health plans and Children's Health Insurance Program (CHIP) populations to learn more about member satisfaction and experiences with care. The standardized survey instrument administered to adult Medicaid members of the QI health plans was the CAHPS 5.0H Adult Medicaid Health Plan Survey. The standardized survey instrument administered to parents/caretakers of child members enrolled in CHIP was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with

[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.
[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

chronic conditions [CCC] measurement set). All sampled members completed the surveys from February to May 2018. HSAG aggregated and produced a final report in September 2018.

- *Provider Survey*. The MQD conducted surveys to healthcare providers who serve QI members through one or more QI health plans to learn more about providers' perceptions of the QI health plans. HSAG and the MQD developed a survey instrument designed to acquire provider information and gain providers' insight into the QI health plans' performance and potential areas of performance improvement. Providers completed the surveys from September to November 2018. HSAG aggregated and produced a final report in February 2019.

# Overall Summary of Health Plan Performance

## *Compliance Monitoring Review*

For the 2018 reevaluation of health plan compliance, HSAG used a monitoring tool to assess and document the health plans' implementation of corrective actions in any standards where deficiencies had been identified during the 2017 review. The standards were related to select health plan requirements, as described in the managed care regulations at 42 CFR §438.

### Findings, Conclusions, and Recommendations

The following table illustrates each plan's individual performance on resolving its CAP areas, and a statewide total for the six plans overall.

**Table 1-1—Total CAPs and Resolved CAPs by Health Plan and by Standard**

| Standard Name | AlohaCare QI | HMSA QI | KHFP QI | 'Ohana QI | UHC CP QI | 'Ohana CCS | Total # CAPs per Standard |
|---|---|---|---|---|---|---|---|
| I. Provider Selection | NA | NA | NA | NA | NA | NA | **NA** |
| II. Subcontracts and Delegation | 1/1 | NA | 2/7 | NA | NA | NA | **3/8** |
| III. Credentialing | 2/2 | 4/4 | 2/7 | 6/6 | 7/7 | 5/5 | **26/31** |
| IV. Quality Assessment and Performance Improvement | NA | NA | NA | NA | NA | 1/1 | **1/1** |
| V. Health Information Systems | NA | NA | NA | NA | NA | NA | **NA** |
| VI. Practice Guidelines | NA | NA | NA | NA | NA | NA | **NA** |
| **Total # CAPs and Resolved CAPs by Health Plan:** | **3/3** | **4/4** | **4/14** | **6/6** | **7/7** | **6/6** | **30/40** |

*Numerator = # of CAPs "closed" and found compliant during follow-up review.*
*Denominator = Total # CAPs required for the standard following prior year (2017) compliance review.*
*NA = Not Applicable. Reevaluation was not necessary as the health plan achieved 100 percent for the standard.*

The QI health plans' CAP implementation resulting from HSAG's 2017 compliance review was monitored by HSAG and the MQD. All five QI health plans and CCS had continuing corrective actions

implemented in 2018, mostly related to credentialing policies and procedures and delegation contracts and oversight monitoring. Following completion of its CAPs, each plan submitted documentation for HSAG's desk review to ensure that the deficiencies were resolved and that compliance was attained. As needed, health plans were provided additional technical assistance and monitoring until compliant with each standard. The results of each reevaluation were provided to the plan and the MQD as a record of how the deficiencies were addressed. AlohaCare QI, HMSA QI, 'Ohana QI and CCS, and UHC CP QI completed the CAPs in 2018. KFHP QI has outstanding CAP items to complete in 2019.

Calendar year 2019 will begin a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program.

## *Validation of Performance Measures—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 *2018 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.[1-6] 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 2017 (January 1, 2017, through December 31, 2017), and the audit activities were conducted concurrently with HEDIS 2018 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 32 measures, yielding a total of 77 measure indicators, for the QI population. 'Ohana CCS was required to report on 9 measures, yielding a total of 21 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 the following:

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

[1-6] 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 3, 2019.

- 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 IS standards during the 2018 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 4.0 = *Partially Compliant*) and HMSA QI (IS 4.0 = *Partially Compliant.).* Overall, the health plans followed the NCQA HEDIS 2017 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of *Reportable* except for Aloha Care QI and HMSA QI, which received a *Biased Rate* designation for the *Comprehensive Diabetes Care HbA1c Control (<7.0%)* indicator.

### Performance Measure Results

HSAG analyzed the performance measure results for each health plan, and where applicable, HSAG compared the results to NCQA's Quality Compass[1-7] national Medicaid HMO percentiles for HEDIS 2017. For two measure indicators where a lower rate indicates better performance (*Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Ambulatory Care—ED Visits—Total)*, 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 performance measure indicators that were compared to the HEDIS 2017 national Medicaid percentiles for QI and CCS. Rates for which comparisons to national percentiles were not appropriate or rates that were not reportable (e.g., small denominator, biased rate) were not included in the following summary results.

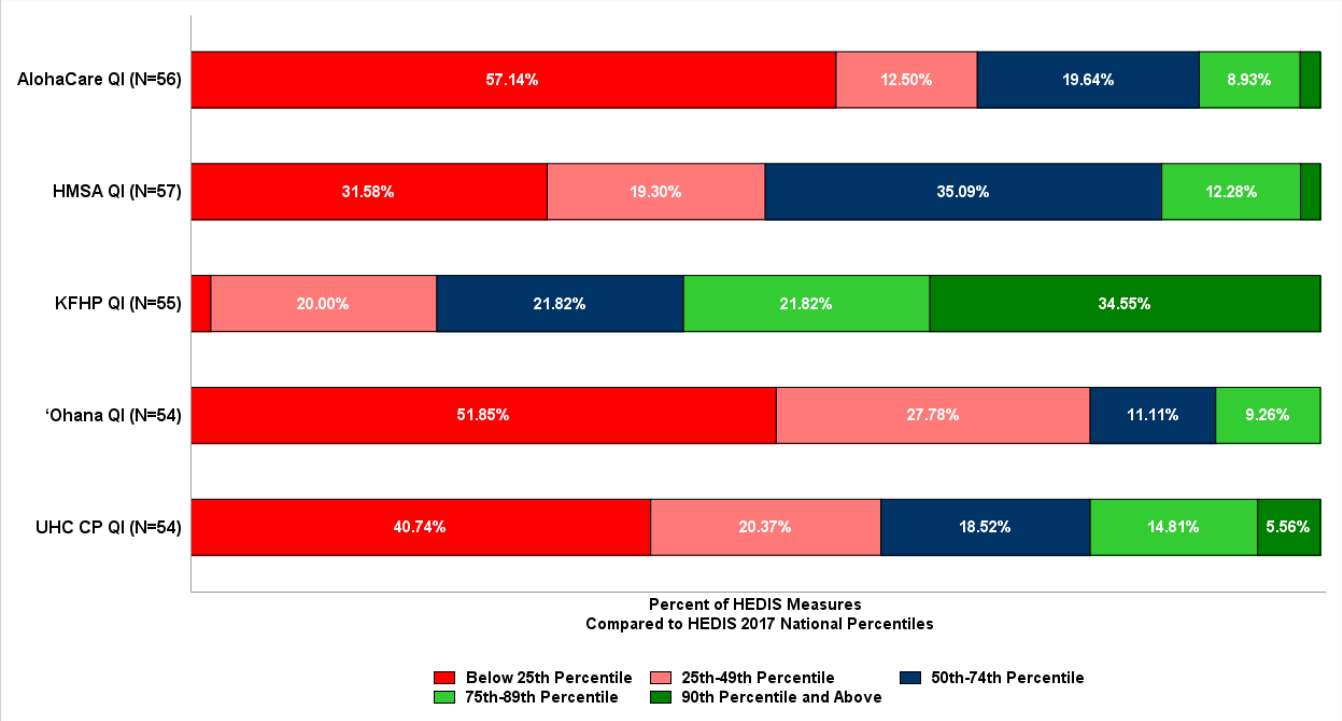
HSAG analyzed results from 29 HEDIS 2018 performance measures (a total of 94 separate indicator rates), of which 59 indicators were comparable to national Medicaid HEDIS 2017 percentiles.[1-9] None of the health plans had reportable rates for all 59 indicators, due to an audit designation of *NA* (small denominator) or *BR* (biased rate). Of note, AlohaCare QI and HMSA QI reported a biased rate (*BR*) for the *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<7.0%)* measure indicator. Figure 1-1 displays the QI health plans' 2018 performance on those measure indicators that could be compared to national Medicaid percentiles.

[1-7] Quality Compass® is a registered trademark of the NCQA.

[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 information only and are not compared to national percentiles.

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



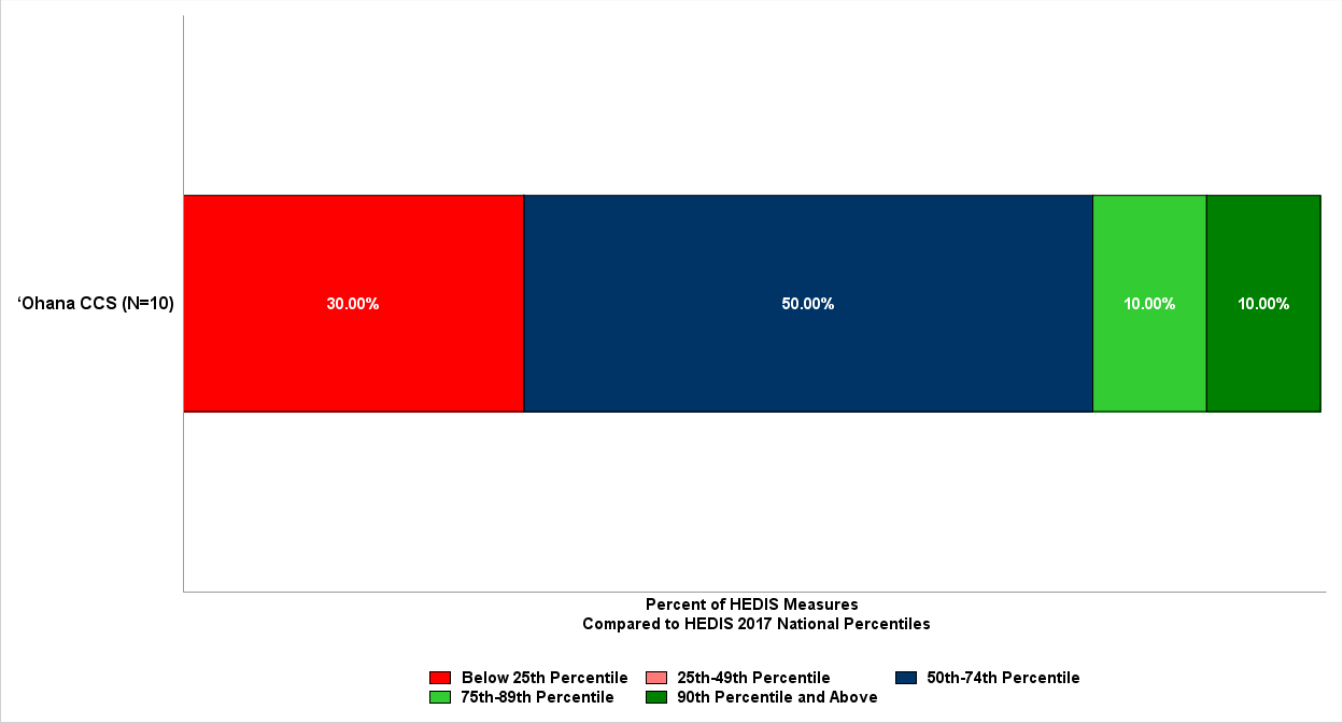

As presented in Figure 1-1, the health plans were diverse in their performance for HEDIS 2018. KFHP QI, the highest-performing plan, reported 19 of 55 (34.6 percent) measure rates at or above the national Medicaid 90th percentile, along with 12 (21.8 percent) measure rates at or above the 75th percentile but below the 90th percentile. HMSA QI was the second-highest performing health plan with 28 of 57 (49.1 percent) measure rates reported at or above the national Medicaid 50th percentile, with eight of these rates (14.0 percent) above the 75th percentile. Additionally, UHC CP QI performed moderately, with 21 of 54 (38.9 percent) measure rates reported at or above the national Medicaid 50th percentile, and just over one-fifth of these rates (20.4 percent) at or above the 75th percentile.

Conversely, AlohaCare QI and 'Ohana QI were the lowest-performing plans, each with more than two-thirds of its measure rates ranking below the national 50th percentile (69.6 percent and 79.6 percent of measure rates, respectively). Of note, AlohaCare QI reported that one measure rate ranked at or above the national Medicaid 90th percentile, while 'Ohana QI had no measures ranked in this category. Moreover, both AlohaCare QI and 'Ohana QI reported more than half of their measure rates (57.1 percent and 51.9 percent, respectively) below the national Medicaid 25th percentile, indicating considerable room for improvement.

Additionally, 12 of 15 measures with MQD Quality Strategy targets were comparable to benchmarks for HEDIS 2018. KFHP QI demonstrated positive performance, meeting 10 of 12 targets (83.3 percent). Conversely, the remaining four QI health plans demonstrated opportunities to improve care overall by meeting one-third or less of the targets: AlohaCare QI (one target met), HMSA QI (four targets met), 'Ohana QI (three targets met), and UHC CP QI (four targets met).

Figure 1-2 displays the ‘Ohana CCS’ 2018 performance on those measure indicators that could be compared to the national percentiles. ‘Ohana CCS had two measure rates with denominators less than 30 for which valid rates could not be reported.

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




‘Ohana CCS demonstrated overall strength, with rates for 70.0 percent of measures ranking at or above the national Medicaid 50th percentile. Conversely, 30.0 percent of ‘Ohana CCS’ health plan’s measure rates fell below the national Medicaid 25th percentile, indicating opportunities for improvement. Due to technical specification changes, comparison to the MQD Quality Strategy targets for ‘Ohana CCS was not appropriate for HEDIS 2018.

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

## *Performance Improvement Projects*

PIPs are an organized way for health plans to assess healthcare processes and design interventions to improve member health, functional status, and/or satisfaction. The MQD required the health plans to conduct PIPs based on plan-specific data that demonstrated a need for improvement. The QI health plan PIP topics were *Getting Needed Care*, *Prenatal and Postpartum Care*, and *Medication Management for People With Asthma*. ‘Ohana CCS’ PIP topics were *Follow-Up After Hospitalization for Mental Illness*

*Within 7 Days of Discharge* and *Improving Behavioral Health Assessment Completion Rates*. After the MQD specified the overarching PIP topics, each health plan analyzed its data to identify a narrowed focus.

HSAG developed a new PIP framework in 2014 based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement.[1-10] 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 process changes to determine the most effective strategies for achieving real improvement.

For the PIP framework, HSAG developed five modules and a reference guide. Each module includes validation criteria necessary for successful completion of a valid PIP and scored as either *Achieved* or *Not Achieved*.

- Module 1—PIP Initiation: Topic rationale and supporting data; building a PIP team; setting aims and completing a key driver diagram.
- Module 2—SMART Aim Data Collection: The SMART Aim measure and data collection methodology are defined.
- Module 3—Intervention Determination: Quality improvement activities that can impact the SMART Aim—process mapping and failure modes and effects analysis (FMEA) are completed. Interventions are identified.
- Module 4—Plan-Do-Study-Act: Interventions selected from Module 3 are tested and evaluated.
- Module 5—PIP Conclusions: Key findings, outcomes achieved, and lessons learned are summarized.

Upon completion of the PIP with the health plans' submission and validation of Modules 4 and 5, HSAG reports the overall validity and reliability of the findings for each PIP as one of the following:

- *High confidence* = the PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- *Confidence* = the PIP was methodologically sound, the SMART Aim goal was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention (s) tested were clearly linked to the demonstrated improvement.
- *Low confidence* = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.

[1-10] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Apr 3, 2019.

- *Reported PIP results were not credible* = the PIP methodology was not executed as approved.

To illustrate how the rapid-cycle PIP framework aligned with CMS requirements, HSAG completed a crosswalk 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.[1-11] CMS approved HSAG's rapid-cycle PIP approach, and the MQD implemented the process with the health plans in 2015.

## Findings, Conclusions, and Recommendations

In 2018, HSAG validated two PIPs for each of the QI and CCS health plans, for a total of 12 PIPs. All health plans progressed to testing interventions for the rapid-cycle PIPs and submitted Module 4 (intervention testing using PDSA) for each intervention selected for testing. HSAG provided recommendations for the pre-validation review of the Module 4 submissions. Additionally, HSAG completed Module 4 check-ins with the health plans to report on the progress of each PIP. HSAG reviewed the updates and provided recommendations to the health plans and the MQD. In 2018, the health plans had not yet progressed to reporting the PIP's SMART Aim measure outcomes. The health plans will submit the final Module 4 and Module 5 (PIP conclusions) approximately six weeks after the SMART Aim end date (December 31, 2018).

Following validation of the health plans' 2018 PIPs, HSAG concluded:

- The health plans successfully completed Modules 1 through 3 and progressed to Module 4 for each PIP topic. The health plans adequately addressed and incorporated all feedback and recommendations from HSAG for Modules 1 through 3.
- The health plans submitted Module 4 progress updates for each PIP topic upon request.
- The health plans requested PIP technical assistance from HSAG, as needed.

HSAG recommends the following:

- The health plans should ensure that interventions tested for the PIP reach enough members to impact the SMART Aim.
- The health plans should address all Module 4 pre-validation review and progress update feedback in the final submission of Module 4.
- The health plans should clearly link improvement in the SMART Aim to intervention(s) tested for the PIP. The health plans should report numerators, denominators, and percentage results at least monthly for the SMART Aim measure and intervention effectiveness measure(s).
- In Module 5, the health plans should provide an accurate summary of the overall key findings and interpretation of results.

[1-11] 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: Apr 3, 2019.

- The health plans should use the PIP Reference Guide and contact HSAG as often as needed for PIP technical assistance.

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

The CAHPS health plan surveys are standardized survey instruments which measure patients' satisfaction with their healthcare. For 2018, HSAG administered the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members of the QI health plans and the CAHPS 5.0H Child Medicaid Health Plan Survey to a statewide sample of CHIP members who met age and enrollment criteria. All members of sampled adult Medicaid and CHIP members completed the surveys from February to May 2018 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.[1-12] 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 item measures were assessed (*Coordination of Care* and *Health Promotion and Education*). The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the proportion (i.e., percentage) of top-level responses was calculated to determine the question summary rates and global proportions.

### Findings, Conclusions, and Recommendations

Table 1-2 presents the 2018 percentage of top-level responses for the QI Program aggregate compared to the 2017 NCQA adult Medicaid national averages and the corresponding 2016 scores.[1-13,1-14] Additionally, the overall member satisfaction ratings (i.e., star ratings) resulting from the QI Program aggregate's three-point mean scores compared to NCQA's HEDIS benchmarks are displayed below.[1-15]

[1-12] Please note that administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.0H Adult Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required in order to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.

[1-13] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, Kaiser QI, 'Ohana QI, and UHC CP QI.

[1-14] The child population was last surveyed in 2017; therefore, the 2018 adult CAHPS scores are compared to the corresponding 2016 scores.

[1-15] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018.* Washington, DC: NCQA, August 20, 2018.

**Table 1-2—QI Program Adult CAHPS Results**

| | 2016 Scores | 2018 Scores | Star Ratings |
|---|---|---|---|
| **Global Ratings** | | | |
| Rating of Health Plan | 59.2% | 63.1% ▲ | ★★★★ |
| Rating of All Health Care | 56.8% | 56.5% | ★★★★ |
| Rating of Personal Doctor | 64.9% | 66.7% | ★★★★★ |
| Rating of Specialist Seen Most Often | 68.3% | 68.2% | ★★★★★ |
| **Composite Measures** | | | |
| Getting Needed Care | 82.2% | 83.4% | ★★ |
| Getting Care Quickly | 80.3% | 81.8% | ★★ |
| How Well Doctors Communicate | 91.7% | 93.4% ▲ | ★★★★★ |
| Customer Service | 86.1% | 89.3% ▲ | ★★★ |
| Shared Decision Making | 81.6% | 83.1% | NA |
| **Individual Item Measures** | | | |
| Coordination of Care | 84.4% | 84.0% | ★★ |
| Health Promotion and Education | 76.0% | 77.4% | NA |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA adult Medicaid national averages.
▲ indicates the 2018 score is statistically significantly higher than the 2016 score.
▼ indicates the 2018 score is statistically significantly lower than the 2016 score.
NA 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 2018 QI Program's scores to the 2017 NCQA adult Medicaid national averages revealed the following summary results:

- The QI Program's scores were at or above the national averages on 10 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- The QI Program's score was below the national average on one measure, *Getting Care Quickly*.

Comparison of the 2018 QI Program scores to the corresponding 2016 scores revealed the following summary results:

- The 2018 QI Program aggregate scores were statistically significantly higher than the 2016 scores on three measures: *Rating of Health Plan*, *How Well Doctors Communicate*, and *Customer Service*.
- The 2018 QI Program aggregate scores were not statistically significantly lower than the 2016 scores on any of the measures.

Comparison of the QI Program aggregate to the 2018 NCQA HEDIS Benchmarks and Thresholds for Accreditation revealed the following:

- The QI Program scored at or above the 90th percentiles on three measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate*.
- The QI Program did not score below the 25th percentile on any of the measures.

Table 1-3 presents the percentage of top-level responses for the Hawaii CHIP population compared to the 2017 NCQA child Medicaid national averages. As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparison. Additionally, the overall member satisfaction ratings (i.e., star ratings) resulting from the three-point mean scores compared to NCQA's HEDIS benchmarks are displayed below.[1-16]

**Table 1-3—2018 CHIP CAHPS Results**

| | 2017 Scores | 2018 Scores | Star Ratings |
|---|---|---|---|
| **Global Ratings** | | | |
| Rating of Health Plan | 72.2% | 72.4% | ★★★★★ |
| Rating of All Health Care | 69.1% | 67.9% | ★★★★★ |
| Rating of Personal Doctor | 73.8% | 73.2% | ★★★★★ |
| Rating of Specialist Seen Most Often | 72.1% | 75.3%+ | ★★★★★ |
| **Composite Measures** | | | |
| Getting Needed Care | 82.3% | 85.9% | ★★ |
| Getting Care Quickly | 87.1% | 85.0% | ★ |
| How Well Doctors Communicate | 95.5% | 96.4% | ★★★★ |
| Customer Service | 85.2% | 85.9%+ | ★ |
| Shared Decision Making | 80.3% | 79.1% | NA |
| **Individual Item Measures** | | | |
| Coordination of Care | 82.5% | 84.2% | ★★★ |
| Health Promotion and Education | 79.7% | 78.2% | NA |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA child Medicaid national averages.
▲ indicates the 2018 score is statistically significantly higher than the 2017 score.
▼ indicates the 2018 score is statistically significantly lower than the 2017 score.
+ indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

NA 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

[1-16] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018.* Washington, DC: NCQA, August 20, 2018.

An evaluation of the CHIP population's 2018 scores to the 2017 NCQA child Medicaid national averages revealed the following summary results:

- The CHIP population scored at or above the national averages on seven measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- The CHIP population scored below the national averages on four measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service*.

The CHIP population did not score statistically significantly higher or lower in 2018 than in 2017 on any of the measures.

Comparison of the CHIP population's scores to the 2018 NCQA HEDIS Benchmarks and Thresholds for Accreditation revealed the following:

- The CHIP population scored at or above the 90th percentiles on four measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*.
- The CHIP population scored below the 25th percentiles on two measures: *Getting Care Quickly* and *Customer Service*.

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

## Provider Survey

HSAG conducted a provider survey during 2018 at the request of the MQD. The objective of this activity was to provide meaningful information to the MQD and the QI health plans about providers' perceptions of the QI health plans. The results of the 2018 Hawaii Provider Survey questions were presented by six domains of satisfaction (general positions, providing quality care, non-formulary, service coordinators, specialists, and substance abuse). Response options to each question within the six domains were classified into one of three response categories: satisfied, neutral, and dissatisfied; or positive impact, neutral impact, and negative impact. For each question, the proportion (i.e., percentage) of responses in each response category was calculated. As is standard in most survey implementations, a top-box rate is defined by a positive or satisfied response.[1-17]

[1-17] For this report, only the top-box rates are displayed. For more detailed results on the other response categories, please see the 2018 Hawaii Provider Survey full report.

## Findings, Conclusions, and Recommendations

Table 1-4 presents the 2018 percentage of top-box rates for the QI Program aggregate compared to the corresponding 2016 top-box rates, where applicable.[1-18]

**Table 1-4—QI Program Provider Survey Results**

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Trend Analysis Significance |
|---|---|---|---|
| **General Positions** | | | |
| Compensation Satisfaction | 26.9% | 30.4% | — |
| Timeliness of Claims Payments | 40.8% | 45.2% | — |
| **Providing Quality Care** | | | |
| Prior Authorization Process | 13.9% | 20.1% | ▲ |
| Formulary | 18.0% | 21.3% | — |
| **Non-Formulary** | | | |
| Adequate Access to Non-Formulary Drugs | 16.8% | 26.9% | ▲ |
| **Service Coordinators** | | | |
| Helpfulness of Service Coordinators | 24.3% | 33.3% | ▲ |
| **Specialists** | | | |
| Adequacy of Specialists | 21.0% | 30.5% | ▲ |
| Adequacy of Behavioral Health Specialists | 10.1% | 10.1% | — |
| Availability of Mental Health Providers | NA | 17.9% | NT |
| **Substance Abuse** | | | |
| Access to Substance Abuse Treatment | NA | 21.0% | NT |

▲ *Indicates the 2018 top-box rate is statistically significantly higher than the 2016 top-box rate.*

▼ *Indicates the 2018 top-box rate is statistically significantly lower than the 2016 top-box rate.*

— *Indicates the 2018 top-box rate is not statistically significantly different than the 2016 top-box rate.*

*NA indicates that this measure was not included in the 2016 survey administration; therefore, 2016 top-box rates are not available.*

*NT indicates that this measure was not included in the 2016 survey administration; therefore, the results for this measure are not trendable.*

[1-18] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, ‘Ohana QI, and UHC CP QI.

Comparison of the 2018 QI Program's rates to the corresponding 2016 top-box rates revealed the following summary results:

- The QI Program scored statistically significantly higher in 2018 than 2016 on four measures: *Prior Authorization Process*, *Adequate Access to Non-Formulary Drugs*, *Helpfulness of Service Coordinators*, and *Adequacy of Specialists*.
- The QI Program did not score statistically significantly lower in 2018 than 2016 on any measures.

The 2018 Provider Survey revealed that while satisfaction has somewhat increased since the 2016 Provider Survey, dissatisfaction remains high across all key survey domains for all QI health plans, except for KFHP QI.

Although the survey does not provide detailed information regarding the specific factors affecting provider satisfaction, a review of the results suggests several areas on which to focus improvement efforts.

- While addressing provider compensation and the availability of physicians is complicated, HSAG recommends engaging the QI health plan and providers in a time-limited workgroup designed to:
  - Identify and define specific factors influencing providers' level of satisfaction in key survey domains.
  - Identify differences in QI health plan reimbursement strategies and how those strategies impact providers' level of satisfaction with reimbursement.

  It is important to note that the purpose of the workgroup is to better define the issues underlying provider satisfaction levels and to increase engagement with both the provider community and the health plans with which they are contracted.
- Providers contracted with 'Ohana QI and UHC CP QI exhibited substantially higher levels of dissatisfaction compared to the other QI health plans across all survey domains. This finding suggests healthcare operations surrounding provider reimbursement, service authorizations and coverage, and provider networks may be affecting providers disproportionately for these two health plans. HSAG recommends that the MQD conduct a targeted inquiry of 'Ohana and UHC CP QI health plans to identify and evaluate the source and validity of providers' concerns. Based on the results of its review, the MQD can work with 'Ohana QI and UHC CP QI to implement improvement actions, where appropriate, to address provider satisfaction.
- HSAG recommends the MQD, in collaboration with the QI health plans, implement a time-limited focus group to review concerns related to the prior authorization (PA) of inter-island travel to determine (1) the degree to which PA impacts patient care of outer-island members, and (2) alternative solutions to coordinating and streamlining PA for nonclinical services (e.g., travel to specialists on Oahu).

# 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: Jan 16, 2019.

## 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 MCOs, PIHPs, PAHPs, or PCCM entities as described at 42 CFR §438.358(d).

## Summary of Report Content

Encompassing a review period from January 1, 2018, through December 31, 2018, 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 350,000[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 July 2018, as cited in *Hawaii Medicaid Enrollment for the Year 2018*, available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/enrollment-reports/2018-New-Enrollment-Reports-updated-201812.pdf Accessed on: Jan 16, 2019.

[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: Jan 16, 2019.

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 65,000 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 165,000 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 40,000 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 48,000 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 §438.340, 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: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/quality-strategy/7-7-2016-HI-MQD-Quality-Strategy-Approved.pdf. Accessed on Jan 16, 2019.

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 2018, the health plans tested and evaluated selected 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.

# 3. Assessment of Health Plan Performance

## Introduction

This section of the report describes the results of HSAG's 2018 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 QUEST Integration (QI) 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 MCO—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 and timeliness of, and access to, care delivered to beneficiaries.

Appendix A of this report contains detailed information about the methodologies used to conduct each of the 2018 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*

The 2018 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2017 review.

### Findings

Table 3-1 presents the scores from HSAG's 2017 compliance review, the number of CAPs required, and the results of the 2018 follow-up reviews of AlohaCare QI.

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

| Standard # | Standard Name | 2017 Compliance Review Score | # of CAPs Required | # of CAPs Closed | 2018 Final Follow-Up Review Score |
|---|---|---|---|---|---|
| I | Provider Selection | 100% | 0 | NA | **100%** |
| II | Subcontracts and Delegation | 94% | 1 | 1 | **100%** |
| III | Credentialing | 94% | 2 | 2 | **100%** |
| IV | Quality Assessment and Performance Improvement | 100% | 0 | NA | **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 | 2017 Compliance Review Score | # of CAPs Required | # of CAPs Closed | 2018 Final Follow-Up Review Score |
|---|---|---|---|---|---|
| V | Health Information System | 100% | 0 | NA | **100%** |
| VI | Practice Guidelines | 100% | 0 | NA | **100%** |
| | **Totals** | **96%** | **3** | **3** | **100%** |

***NA*:** Not Applicable. Reevaluation was not necessary as the health plan achieved 100% for the standard.

### Strengths

Since AlohaCare QI performed well during the 2017 compliance review, only three corrective action items needed to be completed in 2018. To address the *Subcontracts and Delegation* standard deficiency, AlohaCare QI executed a new business associate agreement containing all required federal and state provisions with its pharmacy benefits manager (PBM). To address the *Credentialing* standard deficiencies, AlohaCare QI completed recredentialing of organizational providers and conducted on-site quality assessments of the nonaccredited organizational providers. In addition, AlohaCare QI revised its recredentialing notification letter to ensure organizational providers submit a completed Disclosure of Ownership form at the time of recredentialing. AlohaCare QI contracted with IntelliCVO to ensure timely and complete credentialing activities.

### Areas for Improvement

As a result of its CAP interventions, AlohaCare QI was found to be fully compliant with the *Subcontracts and Delegation* and *Credentialing* standards and had no continuing corrective actions.

## *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. AlohaCare QI was found to be *Fully Compliant* with all IS assessment standards except IS 4.0, 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 four nonstandard supplemental data sources for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2018 measure reporting. All convenience samples passed HSAG's review.

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

- Regarding the integration of behavioral health data from 'Ohana CCS, HSAG recommends that the data be integrated for data reporting to ensure accuracy of reporting on services received by members.

- HSAG recommends that AlohaCare QI improve oversight to ensure all state-required measures are included in the list provided to its vendors responsible for measure calculation, hybrid sample selection, and other medical record review related tasks. AlohaCare QI should proactively trend to anticipate exclusion counts and ensure that the selected oversample will accommodate for required exclusions and valid data errors.

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, except *Comprehensive Diabetes Care*, which received the audit result of *Biased Rate* for the *HbA1c Control (<7.0%) indicator*. For AlohaCare QI reporting, the *Cardiovascular Monitoring for People with Cardiovascular Disease* and *Schizophrenia, Follow-Up Care for Children Prescribed ADHD Medication*, and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* measure indicators received a designation of *Small Denominator* (NA).

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—*Controlling High Blood Pressure*
- Group B: Anticipatory Guidance & Counseling—*Weight Assessment and Counseling for Nutrition* and *Physical Activity for Children/Adolescents—Physical Activity*
- Group C: Laboratory—*Cervical Cancer Screening*
- Group D: Immunization & Other Screenings—*IMA combo 2*
- 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 relative improvement or decline of more than 10 percent in 2018. One measure rate (*Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*) ranked at or above the national Medicaid 50th percentile but below the 75th percentile, with the remaining seven measure rates ranking below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2018.

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

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adults' Access to Preventive/Ambulatory Health Services*** | | | | |
| *20–44 Years* | 62.04% | 60.30% | -2.80% | ★ |
| *45–64 Years* | 74.27% | 72.80% | -1.98% | ★ |
| *65 Years and Older* | 81.52% | 79.98% | -1.89% | ★ |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Total* | 66.97% | 65.66% | -1.96% | ★ |
| ***Children and Adolescents' Access to Primary Care Practitioners*** | | | | |
| *12–24 Months* | 94.23% | 95.88% | 1.75% | ★★★ |
| *25 Months–6 Years* | 81.98% | 83.78% | 2.20% | ★ |
| *7–11 Years* | 85.86% | 85.81% | -0.06% | ★ |
| *12–19 Years* | 83.68% | 83.74% | 0.07% | ★ |
| ***Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment***[1] | | | | |
| *Initiation of AOD Treatment—Total—Total* | — | 38.77% | — | NC |
| *Engagement of AOD Treatment—Total—Total* | — | 10.54% | — | NC |

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Children's Preventive Health Performance Measure Results

Table 3-3 shows AlohaCare QI's Children's Preventive Health performance measure results for HEDIS 2018. Four rates in this domain reported a relative improvement of more than 10 percent. Additionally, five measure rates ranked at or above the national Medicaid 50th percentile, with one of these rates (*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*) at or above the 90th percentile. Conversely, 11 measure rates ranked below the national Medicaid 25th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (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**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adolescent Well-Care Visits*** | | | | |
| *Adolescent Well-Care Visits* | 38.93% | 49.64% | 27.51% | ★★ |
| ***Childhood Immunization Status*** | | | | |
| *Combination 3* | 61.31% | 59.61% | -2.77% | ★ |
| *DTaP* | 65.45% | 64.72% | -1.12% | ★ |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Hepatitis B* | 82.97% | 80.54% | -2.93% | ★ |
| *HiB* | 82.48% | 78.83% | -4.43% | ★ |
| *IPV* | 82.24% | 80.29% | -2.37% | ★ |
| *MMR* | 82.48% | 80.54% | -2.35% | ★ |
| *Pneumococcal Conjugate* | 66.18% | 64.23% | -2.95% | ★ |
| *VZV* | 81.51% | 78.83% | -3.29% | ★ |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 50.36% | 51.82% | 2.90% | ★ |
| *Combination 2 (Meningococcal, Tdap, HPV)*[1] | — | 22.38% | — | NC |
| *HPV*[1] | — | 24.33% | — | NC |
| *Meningococcal* | 53.04% | 55.47% | 4.58% | ★ |
| *Tdap* | 57.66% | 56.69% | -1.68% | ★ |
| ***Well-Child Visits in the First 15 Months of Life*** | | | | |
| *No Well-Child Visits** | 2.19% | 0.97% | -55.71% | ★★★★ |
| *Six or More Well-Child Visits* | 67.88% | 72.75% | 7.17% | ★★★★★ |
| ***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% | 66.42% | 1.11% | ★★ |
| ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | |
| *BMI Percentile—Total* | 80.78% | 84.43% | 4.52% | ★★★★ |
| *Counseling for Nutrition—Total* | 65.21% | 73.48% | 12.68% | ★★★ |
| *Counseling for Physical Activity—Total* | 60.34% | 71.05% | 17.75% | ★★★★ |

** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Women's Health Performance Measure Results

AlohaCare QI's Women's Health performance measure results are shown in Table 3-4. Two rates in this domain reported a relative decline in performance of more than 10 percent in 2018 (*Chlamydia Screening in Women—16–20 Years* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care).* All six measure rates that could be compared to benchmarks ranked below the national Medicaid 25th

percentile. There were two measures[3-6] in this domain with MQD Quality Strategy targets for HEDIS 2018 (i.e., *Cervical Cancer Screening* 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**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Breast Cancer Screening***[1] | | | | |
| *Breast Cancer Screening* | — | 47.48% | — | NC |
| ***Cervical Cancer Screening*** | | | | |
| *Cervical Cancer Screening* | 53.77% | 48.42% | -9.95% | ★ |
| ***Chlamydia Screening in Women*** | | | | |
| *16–20 Years* | 41.83% | 37.01% | -11.52% | ★ |
| *21–24 Years* | 43.02% | 41.00% | -4.70% | ★ |
| *Total* | 42.42% | 38.94% | -8.20% | ★ |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care* | 72.75% | 64.23% | -11.71% | ★ |
| *Postpartum Care* | 55.72% | 51.82% | -7.00% | ★ |

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following 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

Table 3-5 shows AlohaCare QI's Care for Chronic Conditions performance measure results for HEDIS 2018. Two rates in this domain reported a relative improvement of more than 10 percent and ranked at or above the national Medicaid 50th percentile (*Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*). The remaining nine measure rates that could be compared to national benchmarks ranked below the national Medicaid 50th

[3-6] The MQD Quality Strategy targets were established for three measures within the Women's Health domain: *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. Due to technical specification changes in 2018, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Breast Cancer Screening* measure.

percentile, with four of these rates below the 25th percentile. Eight measures[3-7] within this domain were associated with an MQD Quality Strategy target for HEDIS 2018, with AlohaCare QI meeting or exceeding the target for one measure (*Medication Management for People With Asthma—Medication Compliance 75%—Total*).

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

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Annual Monitoring for Patients on Persistent Medications*** | | | | |
| *ACE Inhibitors or ARBs* | 85.71% | 86.44% | 0.85% | ★★ |
| *Diuretics* | 85.90% | 87.26% | 1.58% | ★★ |
| *Total*[1] | — | 86.70% | — | NC |
| ***Comprehensive Diabetes Care*** | | | | |
| *HbA1c Testing* | 78.83% | 79.32% | 0.62% | ★ |
| *HbA1c Poor Control (>9.0%)** | 52.19% | 49.39% | -5.37% | ★ |
| *HbA1c Control (<7.0%)* | 22.37% | BR | — | NC |
| *HbA1c Control (<8.0%)* | 40.69% | 40.15% | -1.33% | ★ |
| *Eye Exam (Retinal) Performed* | 50.73% | 54.50% | 7.43% | ★★ |
| *Medical Attention for Nephropathy* | 84.49% | 87.35% | 3.39% | ★ |
| *Blood Pressure Control (<140/90 mm Hg)* | 52.01% | 55.23% | 6.19% | ★★ |
| ***Controlling High Blood Pressure*** | | | | |
| *Controlling High Blood Pressure* | 48.18% | 47.69% | -1.02% | ★★ |
| ***Medication Management for People With Asthma*** | | | | |
| *Medication Compliance 50%—Total* | 57.00% | 63.77% | 11.88% | ★★★ |
| *Medication Compliance 75%—Total* | 35.10% | 42.51% | 21.11% | ★★★★ |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*BR indicates that the rate was materially biased.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

[3-7] Within this domain, there were 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).

## Behavioral Health Performance Measure Results

AlohaCare QI's Behavioral Health performance measure results are shown in Table 3-6. Five rates reported a relative decline in performance of more than 10 percent in 2018. Additionally, four measure rates ranked below the national Medicaid 25th percentile. Conversely, the remaining eight measure rates compared to benchmarks ranked at or above the national Medicaid 50th percentile but below the 75th percentile. The measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (*Follow-Up After Hospitalization for Mental Illness*) was not appropriate to compare to the established target, the 75th percentile, due to technical specification changes.

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

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Antidepressant Medication Management***[1] | | | | |
| *Effective Acute Phase Treatment* | 50.28% | 55.16% | 9.71% | ★★★ |
| *Effective Continuation Phase Treatment* | 38.47% | 37.67% | -2.08% | ★★★ |
| ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*** | | | | |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | NA | 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% | 71.46% | -3.24% | ★ |
| ***Follow-Up After Emergency Department Visit for AOD Abuse or Dependence***[1] | | | | |
| *7-Day Follow-Up—13-17 Years* | 13.51% | 10.53% | -22.06% | ★★★ |
| *7-Day Follow-Up—18+ Years* | 17.60% | 15.92% | -9.55% | ★★★ |
| *7-Day Follow-Up—Total* | 17.33% | 15.58% | -10.10% | ★★★ |
| *30-Day Follow-Up—13-17 Years* | 16.22% | 10.53% | -35.08% | ★★★ |
| *30-Day Follow-Up—18+ Years* | 25.73% | 23.26% | -9.60% | ★★★ |
| *30-Day Follow-Up—Total* | 25.09% | 22.45% | -10.52% | ★★★ |
| ***Follow-Up After Emergency Department Visit for Mental Illness***[1] | | | | |
| *7-Day Follow-Up* | 27.08% | 26.02% | -3.91% | ★ |
| *30-Day Follow-Up* | 45.84% | 43.21% | -5.74% | ★ |
| ***Follow-Up After Hospitalization for Mental Illness***[2] | | | | |
| *7-Day Follow-Up* | — | 20.83% | — | NC |
| *30-Day Follow-Up* | — | 36.74% | — | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Follow-Up Care for Children Prescribed ADHD Medication***[1] | | | | |
| *Initiation Phase* | 45.65% | 36.90% | -19.17% | ★ |
| *Continuation and Maintenance Phase* | NA | NA | — | NA |

*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## 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. With the exception of *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* and *Plan All-Cause Readmissions*, measure rates in this domain are presented for information only, as lower or higher rates are not indicative of performance. For the *Plan All-Cause Readmissions* measure, performance could not be compared to benchmarks because national benchmarks are not available for the Medicaid product line. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure failed to meet the MQD Quality Strategy target for HEDIS 2018, the 90th percentile.

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

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Ambulatory Care—Total (per 1,000 Member Months)*** | | | | |
| *ED Visits—Total** | 49.18 | 49.15 | -0.06% | ★★★★ |
| *Outpatient Visits—Total* | 278.82 | 280.91 | 0.75% | NC |
| ***Enrollment by Product Line—Total*** | | | | |
| *0–19 Years Subtotal Percentage—Total* | 50.66% | 48.88% | -3.51% | NC |
| *20–44 Years Subtotal Percentage—Total* | 31.04% | 31.57% | 1.71% | NC |
| *45–64 Years Subtotal Percentage—Total* | 15.67% | 16.01% | 2.17% | NC |
| *65+ Years Subtotal Percentage—Total* | 2.63% | 3.55% | 34.98% | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Inpatient Utilization—General Hospital/Acute Care—Total*** | | | | |
| *Maternity—Average Length of Stay—Total* | 2.63 | 2.58 | -1.90% | NC |
| *Maternity—Days per 1,000 Member Months—Total* | 7.75 | 6.99 | -9.81% | NC |
| *Maternity—Discharges per 1,000 Member Months—Total* | 2.95 | 2.72 | -7.80% | NC |
| *Medicine—Average Length of Stay—Total* | 4.75 | 5.33 | 12.21% | NC |
| *Medicine—Days per 1,000 Member Months—Total* | 15.30 | 15.89 | 3.86% | NC |
| *Medicine—Discharges per 1,000 Member Months—Total* | 3.22 | 2.98 | -7.45% | NC |
| *Surgery—Average Length of Stay—Total* | 8.56 | 9.83 | 14.84% | NC |
| *Surgery—Days per 1,000 Member Months—Total* | 12.87 | 14.39 | 11.81% | NC |
| *Surgery—Discharges per 1,000 Member Months—Total* | 1.50 | 1.46 | -2.67% | NC |
| *Total Inpatient—Average Length of Stay—Total* | 4.95 | 5.54 | 11.92% | NC |
| *Total Inpatient—Days per 1,000 Member Months—Total* | 33.58 | 35.21 | 4.85% | NC |
| *Total Inpatient—Discharges per 1,000 Member Months—Total* | 6.79 | 6.36 | -6.33% | NC |
| ***Mental Health Utilization*** | | | | |
| *Any Service—Total*[1] | 8.02% | 8.29% | 3.37% | NC |
| *Inpatient—Total* | 0.43% | 0.31% | -27.91% | NC |
| *Intensive Outpatient or Partial Hospitalization—Total*[1] | 0.06% | 0.08% | 33.33% | NC |
| *Outpatient—Total*[2] | — | 7.93% | — | NC |
| *ED—Total*[2] | — | 0.10% | — | NC |
| *Telehealth—Total*[2] | — | 0.02% | — | NC |
| ***Plan All-Cause Readmissions*** | | | | |
| *Index Total Stays—Observed Readmissions—Ages 18-44** | — | 14.58% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 45-54** | — | 9.77% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 55-64** | — | 11.28% | — | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Index Total Stays—Observed Readmissions—Total** | — | 12.36% | — | NC |

** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Conclusions and Recommendations

Based on HSAG's analyses of AlohaCare QI's 56 measure rates comparable to benchmarks, 17 measure rates (30.4 percent) ranked at or above the national Medicaid 50th percentile, with six of these rates (10.7 percent) above the 75th percentile, indicating positive performance regarding access to care and well-child visits for young children, weight assessment and counseling for children and adolescents, medication management for members with asthma, and low ED utilization. Additionally, AlohaCare QI met one of the MQD Quality Strategy targets for HEDIS 2018 (*Medication Management for People With Asthma—Medication Compliance 75%—Total*).

Conversely, 39 of AlohaCare QI's measure rates that were comparable to national benchmarks (69.6 percent) ranked below the national Medicaid 50th percentile, with 32 of these rates (57.1 percent) below the 25th percentile, suggesting considerable opportunities for improvement across all domains of care. 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—20–44 Years*, *45–64 Years*, *65 Years and Older*, and *Total*
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- Children's Preventive Health
  - *Childhood Immunization Status—Combination 3*, *DTaP*, *Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate*, and *VZV*
  - *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, *Meningococcal*, and *Tdap*

- Women's Health
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women—16–20 Years, 21–24 Years,* and *Total*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%),* and *Medical Attention for Nephropathy*
- Behavioral Health
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
  - *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*

## Validation of Performance Improvement Projects

For validation year 2018, AlohaCare QI submitted two state-mandated PIPs for validation—*Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services* and *Improving Timeliness of Prenatal Care and Postpartum Care*. These rapid-cycle PIPs were implemented in June 2017. The PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

*The Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services* PIP addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The focus of the PIP was to improve members' satisfaction with ease of access to ophthalmology services on the islands of Hawaii, Molokai, and Lanai. The targeted population consisted of members paneled to five community health centers (CHCs)—Bay Clinic, Hamakua Health Center, West Hawaii Community Health Center, Lanai Community Health Center, and Molokai Community Health Center.

The *Improving Timeliness of Prenatal Care and Postpartum Care* PIP addressed CMS' requirements related to quality outcomes—specifically, access to and timeliness of care and services. The focus of the PIP was to increase the percentage of members who received timely prenatal and postpartum care visits. The targeted population consisted of eligible women who receive care at Kalihi-Palama Health Center.

Table 3-8 outlines AlohaCare QI's SMART Aim for each PIP.

**Table 3-8—PIP Topic and SMART Aim Statements for AlohaCare QI**

| PIP Topic | SMART Aim Statement |
|---|---|
| *Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services* | By December 31, 2018, AlohaCare will increase the mean score by 5% using the third question of the member survey as it relates to the ease of access to ophthalmology services reported by members paneled to the five (5) CHCs. |
| *Improving Timeliness of Prenatal Care and Postpartum Care* | By December 31, 2018, AlohaCare aims to increase the timeliness of prenatal care from 73% to 87% and timeliness of postpartum care from 46% to 56% among women seen at Kalihi-Palama Health Center. |

### Findings

AlohaCare successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2018 annual validation cycle and submitted a Module 4 Plan-Do-Study-Act (PDSA) cycle for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2019 annual validation.

### Interventions

AlohaCare QI is testing interventions using PDSA methodology through the SMART Aim end date of December 31, 2018. AlohaCare QI's intervention for the *Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services* PIP involves a reminder call to targeted members two to three business days prior to the scheduled ophthalmologist visit. Members will be reminded of the appointment date and time, flight information, and ground transportation information, as needed.

The health plan provided an update on intervention testing (Module 4) in May 2018 and October 2018. For the October 2018 update, HSAG provided feedback that the health plan should:

- Explain the data in a narrative.
- Include the monthly numerators and denominators for its intervention effectiveness measure in the Module 4 final submission for a better understanding of the numbers of members outreached and the linkage with intervention effectiveness.
- Include a narrative for the second intervention effectiveness measure with the number of survey responses received every month based on when the monthly mean score was calculated.

For the *Improving Timeliness of Prenatal Care and Postpartum Care* PIP, AlohaCare QI's intervention for postpartum care involves incentivizing the Kalihi-Palama Health Center community health workers who develop relationships with members to ensure they receive recommended postpartum care. AlohaCare QI's intervention for prenatal care involves telephonic outreach to newly enrolled pregnant members and female members between 16 and 50 years of age paneled to Kalihi-Palama Health Center who had not accessed women's health services in the past 12 months.

For the October 2018 update, HSAG provided recommendations regarding the data for the intervention effectiveness measures and that the health plan should provide the numerator and denominator data for each monthly result.

### Strengths

AlohaCare QI was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services Diabetes Care* and *Improving Timeliness of Prenatal Care and Postpartum Care* rapid-cycle PIPs.

### Recommendations for Improvement

Based on the 2018 PIP validation, HSAG recommended the following:

- AlohaCare QI should ensure that interventions reach enough members to impact the SMART Aim.
- The health plan should address all Module 4 pre-validation review and progress update feedback in the final submission of Module 4.
- AlohaCare QI should clearly link improvement in the SMART Aim to intervention(s) tested for the PIP. The health plan should report numerators, denominators, and percentage results at least monthly for the SMART Aim measure and intervention effectiveness measure(s).
- AlohaCare QI should work on completing the Module 5 submission form as the PIP progresses.
- AlohaCare QI should test an intervention until the SMART Aim end date, December 31, 2018.
- If the health plan needs to abandon an intervention, it should contact HSAG as soon as possible to discuss next steps.
- AlohaCare QI should use the PIP Reference Guide and contact HSAG as often as needed for technical assistance.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Satisfaction

## Findings

Table 3-9 presents the 2018 percentage of top-level responses for AlohaCare QI compared to the 2017 NCQA adult Medicaid national averages and the corresponding 2016 scores.[3-8,3-9,3-10] Additionally, the overall member satisfaction ratings (i.e., star ratings) resulting from AlohaCare QI's three-point mean scores compared to NCQA's HEDIS benchmarks are displayed below.[3-11]

**Table 3-9—Adult Medicaid CAHPS Results *for* AlohaCare QI**

| Measure | 2016 Scores | 2018 Scores | Star Ratings |
|---|---|---|---|
| **Global Ratings** | | | |
| Rating of Health Plan | 58.9% | 64.7% | ★★★★ |
| Rating of All Health Care | 55.5% | 56.7% | ★★★★★ |
| Rating of Personal Doctor | 61.6% | 67.5% | ★★★★★ |
| Rating of Specialist Seen Most Often | 70.6% | 72.4% | ★★★★★ |
| **Composite Measures** | | | |
| Getting Needed Care | 80.8% | 84.1% | ★★★ |
| Getting Care Quickly | 79.0% | 78.2% | ★ |
| How Well Doctors Communicate | 91.0% | 95.4% ▲ | ★★★★★ |
| Customer Service | 84.6% | 93.3%+ ▲ | ★★★★★ |
| Shared Decision Making | 83.5% | 79.3%+ | NA |
| **Individual Item Measures** | | | |
| Coordination of Care | 85.6% | 88.8%+ | ★★★★ |
| Health Promotion and Education | 81.2% | 78.8% | NA |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA adult Medicaid national averages.
▲ indicates the 2018 score is statistically significantly higher than the 2016 score.
▼ indicates the 2018 score is statistically significantly lower than the 2016 score.
+ indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA 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

[3-8] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI.
[3-9] The child population was last surveyed in 2017; therefore, the 2018 adult CAHPS scores are compared to the corresponding 2016 scores.
[3-10] National Committee for Quality Assurance. *HEDIS® 2018, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2017.
[3-11] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018.* Washington, DC: NCQA, August 20, 2018.

## Strengths

For AlohaCare QI's adult Medicaid population, the following nine measures met or exceeded the 2017 NCQA adult Medicaid national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Customer Service*
- *Coordination of Care*
- *Health Promotion and Education*

In addition, the following two measures scored statistically significantly higher in 2018 than in 2016:

- *How Well Doctors Communicate*
- *Customer Service*

Also, the following five measures met or exceeded the 90th percentiles:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*
- *Customer Service*

Of the three MQD beneficiary satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—AlohaCare QI's member satisfaction ratings for *Rating of Health Plan* and *How Well Doctors Communicate* met or exceeded the 75th percentiles.

## Areas for Improvement

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Getting Care Quickly, Getting Needed Care,* and *Coordination of Care*. HSAG evaluated each of these areas to determine if specific 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," may be driving members' level of satisfaction with each of the priority areas; therefore, AlohaCare QI should consider determining whether potential quality improvement activities

could improve member satisfaction on each of the key drivers identified. Table 3-10 provides a summary of the key drivers identified for AlohaCare QI.

**Table 3-10—AlohaCare QI Key Drivers of Satisfaction**

| Getting Care Quickly |
|---|
| Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one. |
| **Getting Needed Care** |
| Respondents reported that it was often not easy for them to obtain appointments with specialists. |
| Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one. |
| **Coordination of Care** |
| Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them. |
| Respondents reported that their personal doctor did not always spend enough time with them. |

The following observations from the key drivers of satisfaction analysis indicate areas for improvement in access and timeliness for AlohaCare QI:

- Respondents reported that it was often not easy for them to obtain appointments with specialists.
- Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.

The following observation from the key drivers of satisfaction analysis indicates an area for improvement in quality of care for AlohaCare QI:

- Respondents reported that their personal doctor did not always spend enough time with them.

## *Provider Survey*

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

- Plan Comparison
- Trend Analysis

## Findings

Table 3-11 presents the 2018 top-box rates compared to the QI Program aggregate and the corresponding 2016 top-box rates, where applicable, on the six domains of satisfaction for AlohaCare QI.[3-12]

**Table 3-11—Provider Survey Results for AlohaCare QI**

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Plan Comparison Significance | Trend Analysis Significance |
|---|---|---|---|---|
| **General Positions** | | | | |
| Compensation Satisfaction | 25.8% | 36.9% | ↑ | ▲ |
| Timeliness of Claims Payments | 40.7% | 56.4% | ↑ | ▲ |
| **Providing Quality Care** | | | | |
| Prior Authorization Process | 15.2% | 19.6% | — | — |
| Formulary | 18.6% | 19.3% | — | — |
| **Non-Formulary** | | | | |
| Adequate Access to Non-Formulary Drugs | 23.2% | 22.6% | ↓ | — |
| **Service Coordinators** | | | | |
| Helpfulness of Service Coordinators | 26.5% | 37.3% | — | — |
| **Specialists** | | | | |
| Adequacy of Specialists | 14.9% | 23.7% | ↓ | — |
| Adequacy of Behavioral Health Specialists | 9.2% | 7.1% | ↓ | — |
| Availability of Mental Health Providers | NA | 16.2% | — | NT |
| **Substance Abuse** | | | | |
| Access to Substance Abuse Treatment | NA | 19.6% | — | NT |

↑ *Indicates the QI health plan's 2018 top-box rate is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's 2018 top-box rate is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2018 top-box rate is statistically significantly higher than the 2016 top-box rate.*
▼ *Indicates the 2018 top-box rate is statistically significantly lower than the 2016 top-box rate.*
— *Indicates the QI health plan's 2018 top-box rate is not statistically significantly different than the QI Program aggregate or the 2018 top-box rate is not statistically significantly different than the 2016 top-box rate.*
*NA indicates that this measure was not included in the 2016 survey administration; therefore, 2016 top-box rates are not available.*
*NT indicates that this measure was not included in the 2016 survey administration; therefore, the results for this measure are not trendable.*

[3-12] For this report, only the top-box rates are displayed. For more detailed results on the other response categories, please see the 2018 Hawaii Provider Survey full report.

### Strengths

For AlohaCare QI, the following two measures scored statistically significantly higher than the QI Program aggregate and also scored statistically significantly higher in 2018 than in 2016:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*

### Areas for Improvement

For AlohaCare QI, the following three measures scored statistically significantly lower than the QI Program aggregate:

- *Adequate Access to Non-Formulary Drugs*
- *Adequacy of Specialists*
- *Adequacy of Behavioral Health Specialists*

## *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 five EQR activities. While follow-up on compliance monitoring review findings indicated that AlohaCare QI continued to improve its operational foundation to support the quality, access, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

Since AlohaCare QI performed well during the 2017 compliance review, only three corrective action items needed to be completed in 2018. Encompassing the *Subcontracts and Delegation* and *Credentialing* standards, AlohaCare QI took the necessary steps to ensure all of its subcontracts included a complete and accurate set of requirements and that its credentialing policies and procedures were updated and executed to address identified deficiencies. As such, AlohaCare QI continued to show that it had 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, despite a strong infrastructure, health plan performance indicators and member satisfaction scores were generally below the national Medicaid 50th percentile.

Overall, almost three-quarters (70 percent) of AlohaCare QI's measure rates fell below the NCQA national Medicaid 50th percentile across all domains, with 57 percent of the measure rates falling below

the 25th percentile. While some measures showed improvement from 2017, AlohaCare QI's performance suggested several areas needing improvement including the Women's Health domain, where 100 percent of the measure rates were below the 25th percentile. Only one of AlohaCare QI's measure rates met the MQD's Quality Strategy targets.

Similarly, AlohaCare QI's CAHPS results illustrated opportunities for improvement in members' satisfaction. While none of the measures scored statistically significantly lower in 2018 than in 2016, the following one measure rate was below the 25th percentile, *Getting Care Quickly*. Additionally, two of the 11 measures scored below the 2017 NCQA adult Medicaid national averages: *Getting Care Quickly* and *Shared Decision Making.*

Moreover, AlohaCare QI's Provider Survey results suggested that its providers expressed significantly higher satisfaction with compensation, and the timeliness of payments, than reported in 2016. Moreover, AlohaCare QI's provider compensation results were statistically significantly higher than the QI Program aggregate rates. However, providers noted dissatisfaction with the adequacy of access to non-formulary drugs and specialists, especially behavioral health specialists.

Finally, although final results for AlohaCare QI's PIPs were not available in 2018, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services Diabetes Care* and *Improving Timeliness of Prenatal Care and Postpartum Care* rapid-cycle PIPs.

# Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

## *Compliance Monitoring Review*

The 2018 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2017 review.

### Findings

Table 3-12 presents the scores from HSAG's 2017 compliance review, the number of CAPs required, and the results of the 2018 follow-up reviews of HMSA QI.

**Table 3-12—Standards and Compliance Scores—HMSA QI**

| Standard # | Standard Name | 2017 Compliance Review Score | # of CAPs Required | # of CAPs Closed | 2018 Final Follow-Up Review Score |
|---|---|---|---|---|---|
| I | Provider Selection | 100% | 0 | NA | **100%** |
| II | Subcontracts and Delegation | 100% | 0 | NA | **100%** |
| III | Credentialing | 95% | 4 | 4 | **100%** |
| IV | Quality Assessment and Performance Improvement | 100% | 0 | NA | **100%** |
| V | Health Information System | 100% | 0 | NA | **100%** |
| VI | Practice Guidelines | 100% | 0 | NA | **100%** |
| | **Totals** | **97%** | **4** | **4** | **100%** |

***NA*:** Not Applicable. Reevaluation was not necessary as the health plan achieved 100% for the standard.

### Strengths

Since HMSA QI performed well during the 2017 compliance review, only four corrective action items needed to be completed in 2018. To address the *Credentialing* standard deficiencies, HMSA QI revised its recredentialing desk procedure and trained the Credentialing Unit to ensure that providers are assessed at least every three years and that Disclosure of Ownership forms are obtained at recredentialing. In addition, HMSA QI revised its organizational provider credentialing policy to include the acceptable threshold for on-site quality assessments conducted by CMS or an approved survey agency.

### Areas for Improvement

As a result of its CAP interventions, HMSA QI was found to be fully compliant with the *Credentialing* standard and had no continuing corrective actions.

# 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. HMSA QI was found to be *Fully Compliant* with all IS assessment standards except IS 4.0, which was *Partially Compliant*. This demonstrated that HMSA 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. HMSA QI elected to use two standard and one nonstandard supplemental data source for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2018 measure reporting. All convenience samples passed HSAG's review.

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

- HSAG recommended that HMSA QI improve oversight to ensure all state-required measures are included in the list provided to its vendors responsible for measure calculation, hybrid sample selection, and other tasks related to medical record review. HMSA QI should proactively anticipate exclusion counts and ensure that the selected oversample will accommodate for required exclusions and valid data errors.

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, except *Comprehensive Diabetes Care*, which received the audit result of *Biased Rate* for the *HbA1c Control (<7.0%)* indicator. For HMSA QI reporting, the *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* and *Engagement of Alcohol and Other Drug Abuse or Dependence Treatment* measure indicators received a designation of *Small Denominator (NA)*.

HMSA 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. HMSA QI passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Prenatal and Postpartum Care—Postpartum Care*
- Group B: Anticipatory Guidance & Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—*Counseling for Physical Activity (3–11 years)*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- Group D: Immunization & Other Screenings—*IMA Combo 2*
- Group F: Exclusions—All Medical Record Exclusions

## Access to Care Performance Measure Results

HMSA QI's Access to Care performance measure results are shown in Table 3-13. None of the rates in this domain reported a relative improvement or decline of more than 10 percent in 2018. Overall, four of eight measure rates that could be compared to benchmarks ranked at or above the national Medicaid 50th percentile but below the 75th percentile. Conversely, all four *Adults' Access to Preventive/Ambulatory Health Services* rates ranked below the national Medicaid 50th percentile, with three of these rates below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2018.

**Table 3-13—HMSA QI's HEDIS Results for QI Measures Under Access to Care**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adults' Access to Preventive/Ambulatory Health Services*** | | | | |
| *20–44 Years* | 71.43% | 70.26% | -1.64% | ★ |
| *45–64 Years* | 82.37% | 81.40% | -1.18% | ★ |
| *65 Years and Older* | 87.07% | 86.42% | -0.75% | ★★ |
| *Total* | 75.68% | 74.78% | -1.19% | ★ |
| ***Children and Adolescents' Access to Primary Care Practitioners*** | | | | |
| *12–24 Months* | 97.50% | 96.43% | -1.10% | ★★★ |
| *25 Months–6 Years* | 89.48% | 89.27% | -0.23% | ★★★ |
| *7–11 Years* | 92.12% | 91.61% | -0.55% | ★★★ |
| *12–19 Years* | 90.13% | 89.52% | -0.68% | ★★★ |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment***[1] | | | | |
| *Initiation of AOD Treatment—Total—Total* | — | 36.97% | — | NC |
| *Engagement of AOD Treatment—Total—Total* | — | 15.36% | — | NC |

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Children's Preventive Health Performance Measure Results

HMSA QI's Children's Preventive Health performance measure results are shown in Table 3-14. Twelve rates in this domain reported a relative improvement of more than 10 percent in 2018. Additionally, nine measure rates ranked at or above the national Medicaid 50th percentile, with five of these rates above the 75th percentile but below the 90th percentile. Conversely, three measure rates ranked below the national Medicaid 25th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (i.e., *Childhood Immunization Status—Combination 3*), and HMSA QI met or exceeded the established target, the 75th percentile.

**Table 3-14—HMSA QI's HEDIS Results for QI Measures Under Children's Preventive Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adolescent Well-Care Visits*** | | | | |
| *Adolescent Well-Care Visits* | 46.96% | 48.18% | 2.60% | ★★ |
| ***Childhood Immunization Status*** | | | | |
| *Combination 3* | 53.77% | 75.91% | 41.18% | ★★★★ |
| *DTaP* | 64.96% | 81.02% | 24.72% | ★★★ |
| *Hepatitis B* | 70.80% | 86.62% | 22.34% | ★★ |
| *HiB* | 83.21% | 89.78% | 7.90% | ★★★ |
| *IPV* | 78.59% | 87.83% | 11.76% | ★★ |
| *MMR* | 85.16% | 90.02% | 5.71% | ★★ |
| *Pneumococcal Conjugate* | 64.23% | 80.29% | 25.00% | ★★★ |
| *VZV* | 85.40% | 88.81% | 3.99% | ★★ |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 50.12% | 59.85% | 19.41% | ★ |
| *Combination 2 (Meningococcal, Tdap, HPV)*[1] | — | 25.06% | — | NC |
| *HPV*[1] | — | 27.74% | — | NC |
| *Meningococcal* | 54.26% | 63.02% | 16.14% | ★ |
| *Tdap* | 56.20% | 66.91% | 19.06% | ★ |
| ***Well-Child Visits in the First 15 Months of Life*** | | | | |
| *No Well-Child Visits** | 1.67% | 0.93% | -44.31% | ★★★★ |
| *Six or More Well-Child Visits* | 74.72% | 70.09% | -6.20% | ★★★★ |
| ***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* | 73.17% | 78.66% | 7.50% | ★★★★ |
| ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | |
| *BMI Percentile—Total* | 76.16% | 83.94% | 10.22% | ★★★★ |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Counseling for Nutrition—Total* | 62.29% | 73.72% | 18.35% | ★★★ |
| *Counseling for Physical Activity—Total* | 40.88% | 57.66% | 41.05% | ★★ |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Women's Health Performance Measure Results

HMSA QI's Women's Health performance measure results are shown in Table 3-15. None of the rates in this domain reported a relative improvement or decline of more than 10 percent in 2018. One measure rate (*Cervical Cancer Screening*) ranked at or above the national Medicaid 50th percentile but below the 75th percentile. The remaining five measure rates compared to benchmarks ranked below the national Medicaid 50th percentile, with three of these rates below the 25th percentile. Two measures[3-13] in this domain had MQD Quality Strategy targets for HEDIS 2018 (i.e., *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*). None of HMSA QI's measure rates met or exceeded the established MQD Quality Strategy targets.

**Table 3-15—HMSA QI's HEDIS Results for QI Measures Under Women's Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Breast Cancer Screening[1]*** | | | | |
| *Breast Cancer Screening* | — | 62.07% | — | NC |
| ***Cervical Cancer Screening*** | | | | |
| *Cervical Cancer Screening* | 64.63% | 65.00% | 0.57% | ★★★ |
| ***Chlamydia Screening in Women*** | | | | |
| *16–20 Years* | 56.49% | 51.74% | -8.41% | ★★ |
| *21–24 Years* | 58.81% | 56.10% | -4.61% | ★ |

[3-13] The MQD Quality Strategy targets were established for three measures within the Women's Health domain: *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. Due to technical specification changes in 2018, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Breast Cancer Screening* measure.

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Total* | 57.55% | 53.77% | -6.57% | ★★ |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care* | 71.05% | 71.29% | 0.34% | ★ |
| *Postpartum Care* | 50.61% | 49.15% | -2.88% | ★ |

*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Care for Chronic Conditions Performance Measure Results

HMSA QI's Care for Chronic Conditions performance measure results are shown in Table 3-16. Four rates in this domain reported a relative improvement of more than 10 percent in 2018. Additionally, five measure rates ranked at or above the national Medicaid 50th percentile but below the 75th percentile. Conversely, four measure rates ranked below the national Medicaid 25th percentile. Eight measures[3-14] within this domain were associated with an MQD Quality Strategy target for HEDIS 2018, with HMSA QI meeting or exceeding the target for two measures (*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)*).

**Table 3-16—HMSA QI's HEDIS Results for QI Measures Under Care for Chronic Conditions**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Annual Monitoring for Patients on Persistent Medications*** | | | | |
| *ACE Inhibitors or ARBs* | 85.48% | 83.76% | -2.01% | ★ |
| *Diuretics* | 84.66% | 83.44% | -1.44% | ★ |
| *Total*[1] | — | 83.66% | — | NC |
| ***Comprehensive Diabetes Care*** | | | | |
| *HbA1c Testing* | 85.04% | 84.33% | -0.83% | ★★ |
| *HbA1c Poor Control (>9.0%)** | 47.63% | 40.85% | -14.23% | ★★★ |
| *HbA1c Control (<7.0%)* | 32.11% | BR | — | NC |

[3-14] Within this domain, there were 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 | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *HbA1c Control (<8.0%)* | 42.88% | 48.94% | 14.13% | ★★★ |
| *Eye Exam (Retinal) Performed* | 62.04% | 62.85% | 1.31% | ★★★ |
| *Medical Attention for Nephropathy* | 88.50% | 88.20% | -0.34% | ★ |
| *Blood Pressure Control (<140/90 mm Hg)* | 50.91% | 59.15% | 16.19% | ★★ |
| ***Controlling High Blood Pressure*** | | | | |
| *Controlling High Blood Pressure* | 42.82% | 40.63% | -5.11% | ★ |
| ***Medication Management for People With Asthma*** | | | | |
| *Medication Compliance 50%—Total* | 54.73% | 58.74% | 7.33% | ★★★ |
| *Medication Compliance 75%—Total* | 31.62% | 36.49% | 15.40% | ★★★ |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*BR indicates that the rate was materially biased.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Behavioral Health Performance Measure Results

HMSA QI's Behavioral Health performance measure results are shown in Table 3-17. Eight rates within this domain reported a relative decline in performance of more than 10 percent in 2018. Additionally, five measure rates ranked below the national Medicaid 25th percentile. Conversely, the remaining eight measure rates compared to benchmarks ranked at or above the national Medicaid 50th percentile, with two of these rates above the 75th percentile. The measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (*Follow-Up After Hospitalization for Mental Illness*) was not appropriate to compare to the established target, the 75th percentile, due to technical specification changes.

**Table 3-17—HMSA QI's HEDIS Results for QI Measures Under Behavioral Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Antidepressant Medication Management[1]*** | | | | |
| *Effective Acute Phase Treatment* | 48.50% | 47.67% | -1.71% | ★ |
| *Effective Continuation Phase Treatment* | 32.51% | 32.08% | -1.32% | ★ |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*** | | | | |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | NA | 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% | 68.45% | -1.38% | ★ |
| ***Follow-Up After Emergency Department Visit for AOD Abuse or Dependence[1]*** | | | | |
| *7-Day Follow-Up—13-17 Years* | 21.05% | 12.90% | -38.72% | ★★★★ |
| *7-Day Follow-Up—18+ Years* | 32.55% | 16.38% | -49.68% | ★★★ |
| *7-Day Follow-Up—Total* | 31.65% | 16.14% | -49.00% | ★★★ |
| *30-Day Follow-Up—13-17 Years* | 25.00% | 14.52% | -41.92% | ★★★ |
| *30-Day Follow-Up—18+ Years* | 41.16% | 24.88% | -39.55% | ★★★ |
| *30-Day Follow-Up—Total* | 39.90% | 24.15% | -39.47% | ★★★ |
| ***Follow-Up After Emergency Department Visit for Mental Illness[1]*** | | | | |
| *7-Day Follow-Up* | 37.15% | 26.97% | -27.40% | ★ |
| *30-Day Follow-Up* | 58.29% | 44.79% | -23.16% | ★ |
| ***Follow-Up After Hospitalization for Mental Illness[2]*** | | | | |
| *7-Day Follow-Up* | — | 36.94% | — | NC |
| *30-Day Follow-Up* | — | 55.99% | — | NC |
| ***Follow-Up Care for Children Prescribed ADHD Medication[1]*** | | | | |
| *Initiation Phase* | 52.00% | 51.96% | -0.08% | ★★★★ |
| *Continuation and Maintenance Phase* | 60.29% | 57.97% | -3.85% | ★★★ |

*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## 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 3-18. With the exception of *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* and *Plan All-Cause Readmissions*, measure rates in this domain are presented for information only, as lower or higher rates are not indicative of performance. For the *Plan All-Cause Readmissions* measure, performance could not be compared to benchmarks because national benchmarks are not available for the Medicaid product line. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure met or exceeded the MQD Quality Strategy target for HEDIS 2018, the 90th percentile.

**Table 3-18—HMSA QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Ambulatory Care—Total (per 1,000 Member Months)*** | | | | |
| *ED Visits—Total** | 42.51 | 42.11 | -0.94% | ★★★★★ |
| *Outpatient Visits—Total* | 341.05 | 327.07 | -4.10% | NC |
| ***Enrollment by Product Line—Total*** | | | | |
| *0–19 Years Subtotal Percentage—Total* | 53.15% | 51.67% | -2.78% | NC |
| *20–44 Years Subtotal Percentage—Total* | 29.38% | 29.87% | 1.67% | NC |
| *45–64 Years Subtotal Percentage—Total* | 16.29% | 16.68% | 2.39% | NC |
| *65+ Years Subtotal Percentage—Total* | 1.18% | 1.78% | 50.85% | NC |
| ***Inpatient Utilization—General Hospital/Acute Care—Total*** | | | | |
| *Maternity—Average Length of Stay—Total* | 2.55 | 2.52 | -1.18% | NC |
| *Maternity—Days per 1,000 Member Months—Total* | 6.47 | 6.07 | -6.18% | NC |
| *Maternity—Discharges per 1,000 Member Months—Total* | 2.53 | 2.41 | -4.74% | NC |
| *Medicine—Average Length of Stay—Total* | 4.92 | 4.71 | -4.27% | NC |
| *Medicine—Days per 1,000 Member Months—Total* | 11.15 | 10.27 | -7.89% | NC |
| *Medicine—Discharges per 1,000 Member Months—Total* | 2.27 | 2.18 | -3.96% | NC |
| *Surgery—Average Length of Stay—Total* | 6.85 | 7.75 | 13.14% | NC |
| *Surgery—Days per 1,000 Member Months—Total* | 6.73 | 7.25 | 7.73% | NC |
| *Surgery—Discharges per 1,000 Member Months—Total* | 0.98 | 0.94 | -4.08% | NC |
| *Total Inpatient—Average Length of Stay—Total* | 4.47 | 4.54 | 1.57% | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Total Inpatient—Days per 1,000 Member Months—Total* | 22.35 | 21.75 | -2.68% | NC |
| *Total Inpatient—Discharges per 1,000 Member Months—Total* | 5.00 | 4.79 | -4.20% | NC |
| ***Mental Health Utilization*** | | | | |
| *Any Service—Total*[1] | 10.44% | 10.80% | 3.45% | NC |
| *Inpatient—Total* | 0.33% | 0.21% | -36.36% | NC |
| *Intensive Outpatient or Partial Hospitalization—Total*[1] | 0.04% | 0.03% | -25.00% | NC |
| *Outpatient—Total*[2] | — | 10.55% | — | NC |
| *ED—Total*[2] | — | 0.03% | — | NC |
| *Telehealth—Total*[2] | — | 0.03% | — | NC |
| ***Plan All-Cause Readmissions*** | | | | |
| *Index Total Stays—Observed Readmissions—Ages 18-44** | — | 10.05% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 45-54** | — | 10.87% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 55-64** | — | 12.19% | — | NC |
| *Index Total Stays—Observed Readmissions—Total** | — | 10.90% | — | NC |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Conclusions and Recommendations

Based on HSAG's analyses of HMSA QI's 57 measure rates comparable to benchmarks, 28 measure rates (49.1 percent) ranked at or above the national Medicaid 50th percentile, with eight of these rates (14.0 percent) above the 75th percentile, indicating positive performance in immunizations for young children, well-child visits, BMI percentile documentation for children and adolescents, follow-up treatment for children after ED visits for AOD abuse or dependence, follow-up care for children

prescribed ADHD medication, and low ED utilization. Additionally, HMSA QI met four of the MQD Quality Strategy targets for HEDIS 2018.

Conversely, 29 of HMSA QI's measure rates that were comparable to national benchmarks (50.9 percent) ranked below the national Medicaid 50th percentile, with 18 of these rates (31.6 percent) below the 25th percentile, 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—20–44 Years*, *45–64 Years*, and *Total*
- Children's Preventive Health
  - *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, *Meningococcal*, and *Tdap*
- Women's Health
  - *Chlamydia Screening in Women—21–24 Years*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  - *Controlling High Blood Pressure*
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* and *Diuretics*
- Behavioral Health
  - *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Follow-Up After Emergency Department Visit for Mental Health Illness—7-Day Follow-Up* and *30-Day Follow-Up*

## Validation of Performance Improvement Projects

For validation year 2018, HMSA QI submitted two state-mandated PIPs for validation—*Getting Needed Care* and *Improving Timeliness of Prenatal Care and Postpartum Care*. These rapid-cycle PIPs were implemented in June 2017. The PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

The *Getting Needed Care* PIP addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The focus of the PIP was to improve members' satisfaction with access to an

appointment for dermatology, ophthalmology, and psychiatry services as soon as the member felt it was needed. The targeted population consisted of children under the age of 18 years.

The *Improving Timeliness of Prenatal Care and Postpartum Care* PIP addressed CMS' requirements related to quality outcomes—specifically, access to and timeliness of care and services. The focus of the PIP was to increase the percentage of members who received timely prenatal and postpartum care visits. The targeted population consisted of eligible women who receive care at Kokua Kalihi Valley, Waikiki Health Center, or Waimanalo Health Center.

Table 3-19 outlines HMSA QI's SMART Aim for each PIP.

**Table 3-19—PIP Topic and SMART Aim Statements for HMSA QI**

| PIP Topic | SMART Aim Statement |
|---|---|
| *Getting Needed Care* | By December 31, 2018, for QUEST members under the age of 18 who had a specialty office visit of dermatology, ophthalmology, or psychiatry, increase the percentage of "yes" responses to the 2017 Specialist Satisfaction Survey question, "Did your child get an appointment to see Dr.<Name> as soon as you needed?" from 93% to 98%. |
| *Improving Timeliness of Prenatal Care and Postpartum Care* | By December 31, 2018, for members attributed to either Kokua Kalihi Valley, Waikiki Health Center, or Waimanalo Health Center, increase the overall percentage of deliveries that received a prenatal visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment, from 64.8% to 68.0%.<br><br>By December 31, 2018, for members attributed to either Kokua Kalihi Valley, Waikiki Health Center, or Waimanalo Health Center, increase the overall percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery from 28.1% to 30.9%. |

## Findings

HMSA QI successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2018 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2019 annual validation.

## Interventions

HMSA QI is testing interventions using PDSA methodology through the SMART Aim end date of December 31, 2018. HMSA QI's first intervention for the *Getting Needed Care* PIP was to create an online referral tool with internal systems for providers to send and review referrals more quickly. HMSA QI notified HSAG in July 2018 that this intervention was abandoned. HMSA reported a new intervention, a mailed brochure for parents or guardians to use as a guide to schedule and prepare for their child's appointment.

The health plan provided updates on intervention testing (Module 4) in May, July, and October 2018. For the October 2018 update, HSAG provided feedback that the health plan should:

- Ensure that the intervention effectiveness measure data are reported accurately and not the same as the SMART Aim measure data.
- Ensure the numerators and rates reported are correct.
- Document modifications to the intervention in the final Module 4 submission and the intervention effectiveness measure data and analysis after revising the intervention.

For the *Improving Timeliness of Prenatal Care and Postpartum Care* PIP, HMSA QI's first intervention for postpartum care involved offering free communication (language and interpretation) services for federally qualified health centers (FQHCs) to provide to members. HMSA QI's first intervention related to prenatal care involved encouraging and working with each FQHC's case manager/care coordinator to provide telephonic reminders for members. The health plan notified HSAG in July 2018 that these interventions were abandoned. HMSA reported a new intervention for both prenatal and postpartum care which entailed sending informative text messages to members about health and insurance benefits to potentially increase preventive care compliance.

For the October 2018 update, HSAG provided feedback that the health plan should:

- Provide the monthly intervention effectiveness measure results and ensure that the data are accurate.
- Track how many members who received the intervention subsequently attended the appointment.

### Strengths

HMSA QI was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Getting Needed Care* and *Improving Timeliness of Prenatal Care and Postpartum Care* rapid-cycle PIPs.

### Recommendations for Improvement

Based on the 2018 PIP validation, HSAG recommended the following:

- HMSA QI should not use brochures and mailers as interventions for rapid-cycle PIPs. Passive interventions are weak, and it is difficult to evaluate their effectiveness. To understand effectiveness of this type of intervention for the *Getting Needed Care* PIP, the health plan will need to track how many members received a brochure, how many of those members found it helpful, and how providing the brochure subsequently resulted in improved satisfaction with the care provided.
- HMSA QI submitted one Module 4 that covered both prenatal care and postpartum care. The health plan should have two intervention effectiveness measures to track separately the effectiveness of messaging for prenatal care and postpartum care.

- The health plan will need to submit an updated Intervention Determination Table with its final Module 5 submission in February 2019 because it is testing interventions that were not included in Module 3.
- The health plan should address all Module 4 pre-validation review and progress update feedback in the final submission of Module 4.
- HMSA QI should clearly link improvement in the SMART Aim to intervention(s) tested for the PIP. The health plan should report numerators, denominators, and percentage results at least monthly for the SMART Aim measure and intervention effectiveness measure(s).
- HMSA QI should work on completing the Module 5 submission form as the PIP progresses.
- HMSA QI should test an intervention until the SMART Aim end date, December 31, 2018.
- If the health plan needs to abandon an intervention, it should contact HSAG as soon as possible to discuss next steps.
- HMSA QI should use the PIP Reference Guide and contact HSAG as often as needed for technical assistance.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Satisfaction

### Findings

Table 3-20 presents the 2018 percentage of top-level responses for HMSA QI compared to the 2017 NCQA adult Medicaid national averages and the corresponding 2016 scores.[3-15,3-16,3-17] Additionally, the overall member satisfaction ratings (i.e., star ratings) resulting from HMSA QI's three-point mean scores compared to NCQA's HEDIS benchmarks are displayed below.[3-18]

[3-15] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI.
[3-16] The child population was last surveyed in 2017; therefore, the 2018 adult CAHPS scores are compared to the corresponding 2016 scores.
[3-17] National Committee for Quality Assurance. *HEDIS® 2018, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2017.
[3-18] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018.* Washington, DC: NCQA, August 20, 2018.

**Table 3-20—Adult Medicaid CAHPS Results *for* HMSA QI**

| Measure | 2016 Scores | 2018 Scores | Star Ratings |
|---|---|---|---|
| **Global Ratings** | | | |
| Rating of Health Plan | 54.9% | 58.5% | ★★★ |
| Rating of All Health Care | 56.1% | 56.3% | ★★★★ |
| Rating of Personal Doctor | 60.0% | 62.0% | ★★★ |
| Rating of Specialist Seen Most Often | 67.0% | 62.6% | ★★★ |
| **Composite Measures** | | | |
| Getting Needed Care | 84.6% | 82.1% | ★★ |
| Getting Care Quickly | 78.9% | 79.5% | ★★ |
| How Well Doctors Communicate | 92.7% | 91.8% | ★★★★★ |
| Customer Service | 83.0% | 92.6%+ ▲ | ★★★★ |
| Shared Decision Making | 81.0% | 86.0% | NA |
| **Individual Item Measures** | | | |
| Coordination of Care | 83.9% | 85.9% | ★★ |
| Health Promotion and Education | 71.9% | 77.4% | NA |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA adult Medicaid national averages.
▲ indicates the 2018 score is statistically significantly higher than the 2016 score.
▼ indicates the 2018 score is statistically significantly lower than the 2016 score.
+ indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA 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

## Strengths

For HMSA QI's adult Medicaid population, the following seven measures met or exceeded the 2017 NCQA adult Medicaid national averages:

- *Rating of All Health Care*
- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*
- *Coordination of Care*
- *Health Promotion and Education*

In addition, the following one measure scored statistically significantly higher in 2018 than in 2016:

- *Customer Service*

Also, the following one measure met or exceeded the 90th percentile:

- *How Well Doctors Communicate*

Of the three MQD beneficiary satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—HMSA QI's member satisfaction rating for *How Well Doctors Communicate* met or exceeded the 75th percentile.

### Areas for Improvement

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Getting Needed Care*, *Getting Care Quickly*, and *Coordination of Care*. HSAG evaluated each of these areas to determine if specific 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," may be driving members' level of satisfaction with each of the priority areas; therefore, HMSA QI should consider determining whether potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-21 provides a summary of the key drivers identified for HMSA QI.

**Table 3-21—HMSA QI Key Drivers of Satisfaction**

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

The following observations from the key drivers of satisfaction analysis indicate areas for improvement in access and timeliness for HMSA QI:

- Respondents reported that it was often not easy for them to obtain appointments with specialists.
- Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.

The following observation from the key drivers of satisfaction analysis indicates an area for improvement in quality of care for HMSA QI:

- Respondents reported that their personal doctor did not always spend enough time with them.

## Provider Survey

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

- Plan Comparison
- Trend Analysis

### Findings

Table 3-22 presents the 2018 top-box rates compared to the QI Program aggregate and the corresponding 2016 top-box rates, where applicable, on the six domains of satisfaction for HMSA QI.[3-19]

**Table 3-22—Provider Survey Results for HMSA QI**

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Plan Comparison Significance | Trend Analysis Significance |
|---|---|---|---|---|
| **General Positions** | | | | |
| Compensation Satisfaction | 40.8% | 36.2% | ↑ | — |
| Timeliness of Claims Payments | 60.4% | 56.6% | ↑ | — |
| **Providing Quality Care** | | | | |
| Prior Authorization Process | 19.3% | 27.1% | ↑ | — |
| Formulary | 25.2% | 25.1% | ↑ | — |
| **Non-Formulary** | | | | |
| Adequate Access to Non-Formulary Drugs | 21.6% | 21.2% | ↓ | — |
| **Service Coordinators** | | | | |
| Helpfulness of Service Coordinators | 31.0% | 33.0% | — | — |
| **Specialists** | | | | |
| Adequacy of Specialists | 34.7% | 40.8% | ↑ | — |
| Adequacy of Behavioral Health Specialists | 15.3% | 15.6% | ↑ | — |
| Availability of Mental Health Providers | NA | 25.5% | ↑ | NT |

[3-19] For this report, only the top-box rates are displayed. For more detailed results on the other response categories, please see the 2018 Hawaii Provider Survey full report.

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Plan Comparison Significance | Trend Analysis Significance |
|---|---|---|---|---|
| **Substance Abuse** | | | | |
| Access to Substance Abuse Treatment | NA | 23.9% | — | NT |

↑ *Indicates the QI health plan's 2018 top-box rate is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's 2018 top-box rate is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2018 top-box rate is statistically significantly higher than the 2016 top-box rate.*
▼ *Indicates the 2018 top-box rate is statistically significantly lower than the 2016 top-box rate.*
— *Indicates the QI health plan's 2018 top-box rate is not statistically significantly different than the QI Program aggregate or the 2018 top-box rate is not statistically significantly different than the 2016 top-box rate.*
*NA indicates that this measure was not included in the 2016 survey administration; therefore, 2016 top-box rates are not available.*
*NT indicates that this measure was not included in the 2016 survey administration; therefore, the results for this measure are not trendable.*

### Strengths

For HMSA QI, the following seven measures scored statistically significantly higher than the QI Program aggregate:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Prior Authorization Process*
- *Formulary*
- *Adequacy of Specialists*
- *Adequacy of Behavioral Health Specialists*
- *Availability of Mental Health Providers*

### Areas for Improvement

For HMSA QI, the following measure scored statistically significantly lower than the QI Program aggregate:

- *Adequate Access to Non-Formulary Drugs*

## *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 illustrate mixed performance across the five EQR activities. While follow-up on compliance monitoring review findings indicated that HMSA QI continued to improve its operational foundation to support the quality, access, and timeliness of care and service delivery, performance on outcome and process measures showed room for improvement.

Since HMSA QI performed well during the 2017 compliance review, only four corrective action items needed to be completed in 2018. Encompassing the *Credentialing* standard, HMSA QI revised its recredentialing desk procedures and organizational provider credentialing policy to address identified deficiencies. As a result, HMSA QI continued to show that it had 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, despite a strong infrastructure, the health plan's performance on key measure indicators and member satisfaction was moderate, with many of the rates being below the national Medicaid 50th percentile.

Overall, about half (51 percent) of HMSA QI's measures fell below the NCQA national Medicaid 50th percentile across all measurement domains, with nearly one-third (32 percent) of measure rates falling below the 25th percentile. While some measure rates showed improvement from 2017, HMSA QI's performance suggested several areas of improvement including the Women's Health domain, where more than 70 percent of the measure rates failed to meet the 50th percentile. Overall, only four of the MQD's 12 Quality Strategy targets were met in 2018.

Similarly, HMSA QI's CAHPS results illustrated opportunities for improvement in members' satisfaction. While none of the measures scored statistically significantly lower in 2018 than in 2016, the following three measures scored below the 50th percentile: *Getting Needed Care, Getting Care Quickly,* and *Coordination of Care.* Additionally, four of the 11 measures scored below the 2017 NCQA adult Medicaid national averages: *Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Getting Care Quickly.*

Despite lower member satisfaction, HMSA QI's Provider Survey results showed that its providers expressed significantly higher satisfaction across most domains including provider compensation; service authorization; and the adequacy of specialists, behavioral health specialists, and mental health specialists. However, HMSA QI providers noted significantly lower satisfaction with the adequacy of access to non-formulary drugs.

Finally, although final results for HMSA QI's PIPs were not available in 2018, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Getting Needed Care* and *Improving Timeliness of Prenatal Care and Postpartum Care* rapid-cycle PIPs.

# Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

## *Compliance Monitoring Review*

The 2018 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2017 review.

### Findings

Table 3-23 presents the scores from HSAG's 2017 compliance review, the number of CAPs required, and the results of the 2018 follow-up reviews of KFHP QI.

**Table 3-23—Standards and Compliance Scores—KFHP QI**

| Standard # | Standard Name | 2017 Compliance Review Score | # of CAPs Required | # of CAPs Closed | 2018 Final Follow-Up Review Score |
|---|---|---|---|---|---|
| I | Provider Selection | 100% | 0 | NA | **100%** |
| II | Subcontracts and Delegation | 56% | 7 | 2 | **72%** |
| III | Credentialing | 88% | 7 | 2 | **93%** |
| IV | Quality Assessment and Performance Improvement | 100% | 0 | NA | **100%** |
| V | Health Information System | 100% | 0 | NA | **100%** |
| VI | Practice Guidelines | 100% | 0 | NA | **100%** |
| | **Totals** | **88%** | **14** | **4** | **93%** |

***NA*:** Not Applicable. Reevaluation was not necessary as the health plan achieved 100% for the standard.

### Strengths

KFHP QI completed four CAP items during 2018. KFHP QI addressed two CAP items related to the *Subcontracts and Delegation* standard by developing and implementing a Subcontractor Agreement Policy to ensure notification to the State if a subcontractor was terminated and amending its current agreement with the PBM to require that records be retained for seven years to comply with State regulations. To address two CAP items related to the *Credentialing* standard, KFHP QI obtained a completed Disclosure of Ownership form from an organizational provider that had not submitted one as part of recredentialing and developed a Memorandum of Understanding (MOU) with Hawaii Permanente Medical Group (HPMG) to ensure that HPMG complies with the requirement to submit Disclosure of Ownership forms to the health plan.

### Areas for Improvement

KFHP QI received technical assistance and feedback from both the MQD and HSAG throughout the CAP monitoring process. KFHP QI has five uncompleted *Subcontracts and Delegation* standard CAP

items and five uncompleted *Credentialing* standard CAP items to be implemented in early 2019. HSAG and the MQD will review the evidence of implementation submitted by the health plan and provide feedback to ensure successful completion of the remaining CAP items.

## *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. KFHP QI was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that KFHP 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. KFHP QI elected to use one standard and one nonstandard supplemental data source for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2018 measure reporting. All convenience samples passed HSAG's review.

For KFHP QI reporting, the following measures received a designation of *Small Denominator (NA)*: *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up and 30-Day Follow-Up* for ages 13–17 years, *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*, and the measure indicators for *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Alcohol Abuse or Dependence* and *Opioid Abuse or Dependence* for ages 13–17 years.

KFHP QI experienced no enrollment complications related to properly identifying these members on the daily and monthly enrollment files. Eligibility was properly identified within the Common Membership (CM) enrollment system. KFHP QI passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- 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 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 QI's Access to Care performance measure results are shown in Table 3-24. None of the rates in this domain reported a relative improvement or decline of more than 10 percent in 2018. Overall, five measure rates ranked at or above the national Medicaid 50th percentile, with two of these rates (*Adults'*

*Access to Preventive/Ambulatory Health Services—65 Years and Older* and *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*) above the 90th percentile. The remaining three measure rates that were compared to benchmarks ranked below the national Medicaid 50th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2018.

**Table 3-24—KFHP QI's HEDIS Results for QI Measures Under Access to Care**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adults' Access to Preventive/Ambulatory Health Services*** | | | | |
| *20–44 Years* | 77.10% | 74.14% | -3.84% | ★★ |
| *45–64 Years* | 85.34% | 83.64% | -1.99% | ★★ |
| *65 Years and Older* | 95.07% | 94.92% | -0.16% | ★★★★★ |
| *Total* | 80.83% | 78.70% | -2.64% | ★★ |
| ***Children and Adolescents' Access to Primary Care Practitioners*** | | | | |
| *12–24 Months* | 98.40% | 99.23% | 0.84% | ★★★★★ |
| *25 Months–6 Years* | 93.77% | 92.97% | -0.85% | ★★★★ |
| *7–11 Years* | 92.49% | 92.26% | -0.25% | ★★★ |
| *12–19 Years* | 91.78% | 90.99% | -0.86% | ★★★ |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment***[1] | | | | |
| *Initiation of AOD Treatment—Total—Total* | — | 41.95% | — | NC |
| *Engagement of AOD Treatment—Total—Total* | — | 13.83% | — | NC |

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Children's Preventive Health Performance Measure Results

KFHP QI's Children's Preventive Health performance measure results are shown in Table 3-25. Overall, eight measure rates ranked at or above the national Medicaid 75th percentile, with five of these rates above the 90th percentile. An additional eight measure rates ranked at or above the national Medicaid 50th percentile but below the 75th percentile. Conversely, one measure rate (*Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*) demonstrated a large relative decline in performance from HEDIS 2017 but still ranks at or above the 75th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (i.e., *Childhood Immunization Status—Combination 3*), and KFHP QI exceeded the established target, the 75th percentile.

**Table 3-25—KFHP QI's HEDIS Results for QI Measures Under Children's Preventive Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adolescent Well-Care Visits*** | | | | |
| *Adolescent Well-Care Visits* | 44.52% | 43.31% | -2.72% | ★★ |
| ***Childhood Immunization Status*** | | | | |
| *Combination 3* | 79.71% | 80.24% | 0.66% | ★★★★★ |
| *DTaP* | 84.79% | 83.85% | -1.11% | ★★★★ |
| *Hepatitis B* | 93.24% | 92.39% | -0.91% | ★★★ |
| *HiB* | 90.38% | 90.79% | 0.45% | ★★★ |
| *IPV* | 94.02% | 92.26% | -1.87% | ★★★ |
| *MMR* | 92.72% | 91.59% | -1.22% | ★★★ |
| *Pneumococcal Conjugate* | 82.18% | 81.71% | -0.57% | ★★★ |
| *VZV* | 91.81% | 90.92% | -0.97% | ★★★ |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 82.66% | 82.15% | -0.62% | ★★★ |
| *Combination 2 (Meningococcal, Tdap, HPV)*[1] | — | 42.96% | — | NC |
| *HPV*[1] | — | 44.77% | — | NC |
| *Meningococcal* | 85.03% | 84.94% | -0.11% | ★★★ |
| *Tdap* | 84.48% | 83.82% | -0.78% | ★★ |
| ***Well-Child Visits in the First 15 Months of Life*** | | | | |
| *No Well-Child Visits** | 0.14% | 0.57% | 307.14% | ★★★★ |
| *Six or More Well-Child Visits* | 75.04% | 78.97% | 5.24% | ★★★★★ |
| ***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* | 83.34% | 82.36% | -1.18% | ★★★★ |
| ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | |
| *BMI Percentile—Total* | 94.03% | 93.40% | -0.67% | ★★★★★ |
| *Counseling for Nutrition—Total* | 98.51% | 100.00% | 1.51% | ★★★★★ |
| *Counseling for Physical Activity—Total* | 97.01% | 100.00% | 3.08% | ★★★★★ |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Women's Health Performance Measure Results

KFHP QI's Women's Health performance measure results are shown in Table 3-26. Three rates in this domain reported a relative improvement of more than 10 percent in 2018, all related to *Chlamydia Screening in Women*. All six measure rates that could be compared to benchmarks ranked at or above the national Medicaid 75th percentile, with five of these rates above the 90th percentile. There were two measures[3-20] in this domain with MQD Quality Strategy targets for HEDIS 2018 (i.e., *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*). KFHP QI met or exceeded both established MQD Quality Strategy targets.

**Table 3-26—KFHP QI's HEDIS Results for QI Measures Under Women's Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Breast Cancer Screening***[1] | | | | |
| *Breast Cancer Screening* | — | 75.34% | — | NC |
| ***Cervical Cancer Screening*** | | | | |
| *Cervical Cancer Screening* | 76.80% | 79.39% | 3.37% | ★★★★★ |
| ***Chlamydia Screening in Women*** | | | | |
| *16–20 Years* | 65.36% | 78.26% | 19.74% | ★★★★★ |
| *21–24 Years* | 71.43% | 80.63% | 12.88% | ★★★★★ |
| *Total* | 67.84% | 79.21% | 16.76% | ★★★★★ |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care* | 93.23% | 90.00% | -3.46% | ★★★★ |
| *Postpartum Care* | 80.99% | 80.46% | -0.65% | ★★★★★ |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure. NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Care for Chronic Conditions Performance Measure Results

KFHP QI's Care for Chronic Conditions performance measure results are shown in Table 3-27. Two rates in this domain reported a relative improvement of more than 10 percent in 2018, both related to

[3-20] The MQD Quality Strategy targets were established for three measures within the Women's Health domain: *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. Due to technical specification changes in 2018, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Breast Cancer Screening* measure.

*Medication Management for People With Asthma.* Additionally, eight measure rates ranked at or above the national Medicaid 75th percentile, with five of these rates above the 90th percentile. Conversely, one measure rate ranked below the national Medicaid 25th percentile. There were eight measures[3-21] within this domain associated with an MQD Quality Strategy target for HEDIS 2018, with KFHP QI meeting or exceeding the target for six measures (five *Comprehensive Diabetes Care* indicators and *Controlling High Blood Pressure*).

**Table 3-27—KFHP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Annual Monitoring for Patients on Persistent Medications*** | | | | |
| *ACE Inhibitors or ARBs* | 93.67% | 91.37% | -2.46% | ★★★★ |
| *Diuretics* | 93.41% | 90.09% | -3.55% | ★★★ |
| *Total*[1] | — | 90.96% | — | NC |
| ***Comprehensive Diabetes Care*** | | | | |
| *HbA1c Testing* | 95.48% | 92.91% | -2.69% | ★★★★★ |
| *HbA1c Poor Control (>9.0%)** | 30.13% | 30.39% | 0.86% | ★★★★ |
| *HbA1c Control (<7.0%)* | 33.90% | 32.74% | -3.42% | ★★ |
| *HbA1c Control (<8.0%)* | 58.37% | 57.99% | -0.65% | ★★★★ |
| *Eye Exam (Retinal) Performed* | 68.08% | 68.43% | 0.51% | ★★★★★ |
| *Medical Attention for Nephropathy* | 95.08% | 94.42% | -0.69% | ★★★★★ |
| *Blood Pressure Control (<140/90 mm Hg)* | 81.30% | 77.55% | -4.61% | ★★★★★ |
| ***Controlling High Blood Pressure*** | | | | |
| *Controlling High Blood Pressure* | 77.92% | 81.42% | 4.49% | ★★★★★ |
| ***Medication Management for People With Asthma*** | | | | |
| *Medication Compliance 50%—Total* | 42.02% | 48.89% | 16.35% | ★ |
| *Medication Compliance 75%—Total* | 18.59% | 28.08% | 51.05% | ★★ |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

[3-21] Within this domain, there were 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).

## Behavioral Health Performance Measure Results

KFHP QI's Behavioral Health performance measure results are shown in Table 3-28. Six rates in this domain reported a relative decline in performance of more than 10 percent in 2018. Additionally, four measure rates ranked below the national Medicaid 50th percentile. Conversely, five measure rates ranked at or above the national Medicaid 75th percentile, with one of these rates above the 90th percentile. Two rates (*Antidepressant Medication Management—Effective Continuation Phase Treatment* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*) reported a relative improvement of more than 10 percent. The measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (*Follow-Up After Hospitalization for Mental Illness*) was not appropriate to compare to the established target, the 75th percentile, due to technical specification changes.

**Table 3-28—KFHP QI's HEDIS Results for QI Measures Under Behavioral Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Antidepressant Medication Management***[1] | | | | |
| *Effective Acute Phase Treatment* | 44.75% | 48.50% | 8.38% | ★★ |
| *Effective Continuation Phase Treatment* | 28.79% | 34.96% | 21.43% | ★★ |
| ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*** | | | | |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | NA | 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% | 85.00% | 15.91% | ★★★★ |
| ***Follow-Up After Emergency Department Visit for AOD Abuse or Dependence***[1] | | | | |
| *7-Day Follow-Up—13-17 Years* | NA | NA | — | NA |
| *7-Day Follow-Up—18+ Years* | 23.61% | 19.74% | -16.39% | ★★★★ |
| *7-Day Follow-Up—Total* | 23.08% | 18.28% | -20.80% | ★★★★ |
| *30-Day Follow-Up—13-17 Years* | NA | NA | — | NA |
| *30-Day Follow-Up—18+ Years* | 33.33% | 28.95% | -13.14% | ★★★★ |
| *30-Day Follow-Up—Total* | 32.05% | 25.81% | -19.47% | ★★★ |
| ***Follow-Up After Emergency Department Visit for Mental Illness***[1] | | | | |
| *7-Day Follow-Up* | 46.81% | 34.00% | -27.37% | ★★ |
| *30-Day Follow-Up* | 73.05% | 52.00% | -28.82% | ★★ |
| ***Follow-Up After Hospitalization for Mental Illness***[2] | | | | |
| *7-Day Follow-Up* | — | 55.00% | — | NC |
| *30-Day Follow-Up* | — | 74.29% | — | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Follow-Up Care for Children Prescribed ADHD Medication***[1] | | | | |
| *Initiation Phase* | 72.86% | 66.67% | -8.50% | ★★★★★ |
| *Continuation and Maintenance Phase* | NA | NA | — | NA |

*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Utilization and Health Plan Descriptive Information Performance Measure Results

KFHP's Utilization and Health Plan Descriptive Information performance measure results are shown in Table 3-29. With the exception of *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* and *Plan All-Cause Readmissions*, measure rates in this domain are presented for information only, as lower or higher rates are not indicative of performance. For the *Plan All-Cause Readmissions* measure, performance could not be compared to benchmarks because national benchmarks are not available for the Medicaid product line. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure met or exceeded the MQD Quality Strategy target for HEDIS 2018, the 90th percentile.

**Table 3-29—KFHP's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Ambulatory Care—Total (per 1,000 Member Months)*** | | | | |
| *ED Visits—Total** | 29.22 | 31.51 | 7.84% | ★★★★★ |
| *Outpatient Visits—Total* | 277.58 | 264.18 | -4.83% | NC |
| ***Enrollment by Product Line—Total*** | | | | |
| *0–19 Years Subtotal Percentage—Total* | 57.13% | 56.63% | -0.88% | NC |
| *20–44 Years Subtotal Percentage—Total* | 25.89% | 25.82% | -0.27% | NC |
| *45–64 Years Subtotal Percentage—Total* | 15.31% | 15.35% | 0.26% | NC |
| *65+ Years Subtotal Percentage—Total* | 1.67% | 2.20% | 31.74% | NC |
| ***Inpatient Utilization—General Hospital/Acute Care—Total*** | | | | |
| *Maternity—Average Length of Stay—Total* | 2.84 | 2.57 | -9.51% | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Maternity—Days per 1,000 Member Months—Total* | 6.95 | 5.27 | -24.17% | NC |
| *Maternity—Discharges per 1,000 Member Months—Total* | 2.44 | 2.05 | -15.98% | NC |
| *Medicine—Average Length of Stay—Total* | 5.19 | 4.80 | -7.51% | NC |
| *Medicine—Days per 1,000 Member Months—Total* | 10.09 | 9.73 | -3.57% | NC |
| *Medicine—Discharges per 1,000 Member Months—Total* | 1.94 | 2.03 | 4.64% | NC |
| *Surgery—Average Length of Stay—Total* | 6.87 | 6.71 | -2.33% | NC |
| *Surgery—Days per 1,000 Member Months—Total* | 5.03 | 5.28 | 4.97% | NC |
| *Surgery—Discharges per 1,000 Member Months—Total* | 0.73 | 0.79 | 8.22% | NC |
| *Total Inpatient—Average Length of Stay—Total* | 4.59 | 4.43 | -3.49% | NC |
| *Total Inpatient—Days per 1,000 Member Months—Total* | 19.75 | 18.55 | -6.08% | NC |
| *Total Inpatient—Discharges per 1,000 Member Months—Total* | 4.30 | 4.19 | -2.56% | NC |
| ***Mental Health Utilization*** | | | | |
| *Any Service—Total*[1] | 7.55% | 7.10% | -5.96% | NC |
| *Inpatient—Total* | 0.36% | 0.24% | -33.33% | NC |
| *Intensive Outpatient or Partial Hospitalization—Total*[1] | 0.14% | 0.05% | -64.29% | NC |
| *Outpatient—Total*[2] | — | 6.88% | — | NC |
| *ED—Total*[2] | — | 0.06% | — | NC |
| *Telehealth—Total*[2] | — | 0.03% | — | NC |
| ***Plan All-Cause Readmissions*** | | | | |
| *Index Total Stays—Observed Readmissions—Ages 18-44** | — | 12.27% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 45-54** | — | 12.93% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 55-64** | — | 13.40% | — | NC |
| *Index Total Stays—Observed Readmissions—Total** | — | 12.80% | — | NC |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*

[2] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

### Conclusions and Recommendations

Based on HSAG's analyses of KFHP QI's 55 measure rates comparable to benchmarks, 43 measure rates (78.2 percent) ranked at or above the national Medicaid 50th percentile, with 19 of these rates (34.5 percent) ranking at or above the national Medicaid 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met 10 of the MQD Quality Strategy targets for HEDIS 2018: *Childhood Immunization Status—Combination 3*; *Cervical Cancer Screening*; *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; *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 *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*.

Conversely, 12 of KFHP QI's measure rates that were comparable to national benchmarks (21.8 percent) ranked below the national Medicaid 50th percentile, with only one of these rates (1.8 percent) below the 25th percentile, suggesting some opportunities for improvement exist. HSAG recommends that KFHP QI focus on improving performance related to the following measure with a rate that fell below the national Medicaid 25th percentile for the QI population:

- Care for Chronic Conditions
  - *Medication Management for People With Asthma—Medication Compliance 50%—Total*

## *Validation of Performance Improvement Projects*

For validation year 2018, KFHP QI submitted two state-mandated PIPs for validation—*Getting Needed Care* and *Medication Management for People With Asthma, Ages 5–64*. These rapid-cycle PIPs were implemented in June 2017. The PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

The *Getting Needed Care* PIP addressed CMS' requirements related to quality outcomes—specifically, access to and timeliness of care and services. The focus of the PIP was to improve the percentage of members who are seen within 21 days of the initial request for a routine behavioral health evaluation. The targeted population consisted of providers in Oahu.

The *Medication Management for People With Asthma, Ages 5–64* PIP addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The focus of the PIP was to increase the percentage of asthmatic members who have an appropriate asthma medication ratio. The targeted population included members ages 5 to 64 years with home clinic locations of Honolulu, Waipio, and Maui Lani.

Table 3-30 outlines KFHP QI's SMART Aim for each PIP.

**Table 3-30—PIP Topic and SMART Aim Statements for KFHP QI**

| PIP Topic | SMART Aim Statement |
|---|---|
| *Getting Needed Care* | By December 31, 2018, increase the percentage rate at which Adult QUEST Integration members are seen within 21 days of the initial request for an initial routine outpatient Behavioral Health evaluation, by internal providers on Oahu from 50% to 55%. |
| *Medication Management for People With Asthma, Ages 5–64* | By December 31, 2018, decrease the rate of QUEST Integration members, ages 5–64 years old with home clinic locations of Honolulu, Waipio, and Maui Lani, with an Asthma Medication Ratio [AMR] of less than 0.5 from 26.3% to 24.3%. |

### Findings

KFHP QI successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2018 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2019 annual validation.

### Interventions

KFHP QI is testing interventions using PDSA methodology through the SMART Aim end date of December 31, 2018. KFHP's intervention for the *Getting Needed Care* PIP involves member care service associates reaching out to members to provide transportation options.

KFHP provided an update on intervention testing (Module 4) in May, August, and October 2018. For the October 2018 update, HSAG did not have any recommendations for intervention evaluation.

For the *Medication Management for People With Asthma, Ages 5–64* PIP, KFHP's intervention involves identifying and assessing members with an AMR less than 0.5 as needing outreach, and having clinical pharmacists or pharmacy technicians call these members to provide education on when to use controller medication versus a rescue inhaler. For the October 2018 update, HSAG recommended that the health plan ensure that all data are labeled appropriately in the final Module 4 and 5 submissions.

### Strengths and Weaknesses

KFHP QI was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Getting Needed Care* and *Medication Management for People With Asthma, Ages 5–64* rapid-cycle PIPs.

### Recommendations for Improvement

Based on the 2018 PIP validation, HSAG recommended the following:

- KFHP QI should ensure that interventions are targeting and reaching a population large enough to impact the SMART Aim.
- The health plan should address all Module 4 pre-validation review and progress update feedback in the final submission of Module 4.
- KFHP QI should clearly link improvement in the SMART Aim to intervention(s) tested for the PIP. The health plan should report numerators, denominators, and percentage results at least monthly for the SMART Aim measure and intervention effectiveness measure(s).
- KFHP QI should work on completing the Module 5 submission form as the PIP progresses.
- KFHP QI should test an intervention until the SMART Aim end date, December 31, 2018.
- If the health plan needs to abandon an intervention, it should contact HSAG as soon as possible to discuss next steps.
- KFHP QI should use the PIP Reference Guide and contact HSAG as often as needed for technical assistance.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Satisfaction

## Findings

Table 3-31 presents the 2018 percentage of top-level responses for KFHP QI compared to the 2017 NCQA adult Medicaid national averages and the corresponding 2016 scores.[3-22,3-23,3-24] Additionally, the overall member satisfaction ratings (i.e., star ratings) resulting from KFHP QI's three-point mean scores compared to NCQA's HEDIS benchmarks are displayed below.[3-25]

**Table 3-31—Adult Medicaid CAHPS Results *for* KFHP QI**

| Measure | 2016 Scores | 2018 Scores | Star Ratings |
|---|---|---|---|
| **Global Ratings** | | | |
| Rating of Health Plan | 67.0% | 71.7% | ★★★★★ |
| Rating of All Health Care | 63.1% | 60.3% | ★★★★★ |
| Rating of Personal Doctor | 68.1% | 70.5% | ★★★★★ |
| Rating of Specialist Seen Most Often | 66.3% | 68.6% | ★★★★★ |
| **Composite Measures** | | | |
| Getting Needed Care | 83.1% | 83.4% | ★★★ |
| Getting Care Quickly | 80.4% | 82.1% | ★★ |
| How Well Doctors Communicate | 92.4% | 95.4% | ★★★★★ |
| Customer Service | 87.4% | 88.5% | ★★★ |
| Shared Decision Making | 80.2% | 82.6% | NA |
| **Individual Item Measures** | | | |
| Coordination of Care | 83.1% | 85.6% | ★★★ |
| Health Promotion and Education | 74.1% | 73.4% | NA |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA adult Medicaid national averages.
▲ indicates the 2018 score is statistically significantly higher than the 2016 score.
▼ indicates the 2018 score is statistically significantly lower than the 2016 score.
NA 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

[3-22] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI.
[3-23] The child population was last surveyed in 2017; therefore, the 2018 adult CAHPS scores are compared to the corresponding 2016 scores.
[3-24] National Committee for Quality Assurance. *HEDIS® 2018, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2017.
[3-25] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018.* Washington, DC: NCQA, August 20, 2018.

## Strengths

For KFHP QI's adult Medicaid population, the following 10 measures met or exceeded the 2017 NCQA adult Medicaid national averages:

- *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*

In addition, the following five measures met or exceeded the 90th percentiles:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*

Of the three MQD beneficiary satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—KFHP QI's member satisfaction ratings for *Rating of Health Plan* and *How Well Doctors Communicate* met or exceeded the 75th percentiles.

## Areas for Improvement

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Getting Care Quickly*, *Getting Needed Care*, and *Coordination of Care*. HSAG evaluated each of these areas to determine if specific 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," may be driving members' level of satisfaction with each of the priority areas; therefore, KFHP QI should consider determining whether potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-32 provides a summary of the key drivers identified for KFHP QI.

**Table 3-32—KFHP QI Key Drivers of Satisfaction**

| Getting Care Quickly |
|---|
| Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one. |
| **Getting Needed Care** |
| Respondents reported that it was often not easy for them to obtain appointments with specialists. |
| Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one. |
| **Coordination of Care** |
| Respondents reported that when they talked about starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for them. |

The following observations from the key drivers of satisfaction analysis indicate areas for improvement in access and timeliness for KFHP QI:

- Respondents reported that it was often not easy for them to obtain appointments with specialists.
- Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.

The following observation from the key drivers of satisfaction analysis indicates an area for improvement in quality of care for KFHP QI:

- Respondents reported that a doctor or other health provider did not ask what they thought was best for them when they talked about starting or stopping a prescription medicine.

## *Provider Survey*

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

- Plan Comparison
- Trend Analysis

### Findings

Table 3-33 presents the 2018 top-box rates compared to the QI Program aggregate and the corresponding 2016 top-box rates, where applicable, on the six domains of satisfaction for KFHP QI.[3-26]

[3-26] For this report, only the top-box rates are displayed. For more detailed results on the other response categories, please see the 2018 Hawaii Provider Survey full report.

**Table 3-33—Provider Survey Results for KFHP QI**

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Plan Comparison Significance | Trend Analysis Significance |
|---|---|---|---|---|
| **General Positions** | | | | |
| Compensation Satisfaction | 63.4% | 54.2% | ↑ | — |
| Timeliness of Claims Payments | 61.5% | 42.9% | — | — |
| **Providing Quality Care** | | | | |
| Prior Authorization Process | 32.4% | 30.6% | — | — |
| Formulary | 56.3% | 56.4% | ↑ | — |
| **Non-Formulary** | | | | |
| Adequate Access to Non-Formulary Drugs | 72.9% | 85.5% | ↑ | — |
| **Service Coordinators** | | | | |
| Helpfulness of Service Coordinators | 75.0% | 87.7% | ↑ | — |
| **Specialists** | | | | |
| Adequacy of Specialists | 80.0% | 86.2% | ↑ | — |
| Adequacy of Behavioral Health Specialists | 23.9% | 19.6% | ↑ | — |
| Availability of Mental Health Providers | NA | 44.6% | ↑ | NT |
| **Substance Abuse** | | | | |
| Access to Substance Abuse Treatment | NA | 50.9% | ↑ | NT |

↑ *Indicates the QI health plan's 2018 top-box rate is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's 2018 top-box rate is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2018 top-box rate is statistically significantly higher than the 2016 top-box rate.*
▼ *Indicates the 2018 top-box rate is statistically significantly lower than the 2016 top-box rate.*
— *Indicates the QI health plan's 2018 top-box rate is not statistically significantly different than the QI Program aggregate or the 2018 top-box rate is not statistically significantly different than the 2016 top-box rate.*
*NA indicates that this measure was not included in the 2016 survey administration; therefore, 2016 top-box rates are not available.*
*NT indicates that this measure was not included in the 2016 survey administration; therefore, the results for this measure are not trendable.*

## Strengths

For KFHP QI, the following eight measures scored statistically significantly higher than the QI Program aggregate:

- *Compensation Satisfaction*
- *Formulary*

- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Service Coordinators*
- *Adequacy of Specialists*
- *Adequacy of Behavioral Health Specialists*
- *Availability of Mental Health Providers*
- *Access to Substance Abuse Treatment*

### Areas for Improvement

Based on KFHP QI's performance, no critical areas were identified in need of improvement.

## *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 illustrated strong performance across the five EQR activities. While follow-up on compliance monitoring review findings indicated that KFHP QI failed to close most of its CAPs, the health plan continued to improve its operational foundation to support the quality, access, and timeliness of care and service delivery. Moreover, KFHP QI's performance on 2018 HEDIS, CAHPS, and Provider Survey measures indicated high performance in outcomes across all domains.

Although KFHP QI's performance during the 2017 compliance review revealed that the health plan had systems, policies, and staff in place to ensure appropriate structure and operations, 14 corrective action items were required to be implemented in 2018. Encompassing the *Subcontracts and Delegation* and *Credentialing* standards, KFHP QI developed and implemented a new subcontractor policy and began modifying existing contracts and agreements to address identified deficiencies. KFHP QI also began addressing deficiencies associated with credentialing policies and procedures. However, five corrective actions within each standard remained unresolved as of the end of 2018. As such, KFHP QI continued to show 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.

Overall, more than three-quarters (78 percent) of KFHP QI's measure rates exceeded the NCQA national Medicaid 50th percentile across all measurement domains, with over half (56 percent) of the measure rates above the 75th percentile. Conversely, less than 2 percent of the measure rates fell below the 25th percentile. KFHP QI's performance did identify a few areas for improvement including *Care for Chronic Conditions, Access to Care,* and *Behavioral Health* domains. KFHP QI's measure rates met 10 of the 12 MQD Quality Strategy targets.

Similarly, KFHP QI's CAHPS results suggest strong member satisfaction, with five measure results being at or above the 90th percentile. Moreover, KFHP QI scored at or above the national average on 10 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*, and *Coordination of Care.* However, while none of the measures scored statistically significantly lower in 2018 relative to 2016, the following one measure scored below the 50th percentile, *Getting Care Quickly*. KFHP QI met or exceeded two of the three MQD Quality Strategy targets. In addition to comparatively high levels of satisfaction among members, KFHP QI's Provider Survey results also demonstrated high levels of satisfaction among providers across all domains.

Finally, although final results for KFHP QI's PIPs were not available in 2018, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Getting Needed Care* and *Medication Management for People With Asthma, Ages 5–64* rapid-cycle PIPs.

# 'Ohana Health Plan QUEST Integration ('Ohana QI) Results

## *Compliance Monitoring Review*

The 2018 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2017 review.

### Findings

Table 3-34 presents the scores from HSAG's 2017 compliance review, the number of CAPs required, and the results of the 2018 follow-up reviews of 'Ohana QI.

**Table 3-34—Standards and Compliance Scores—'Ohana QI**

| Standard # | Standard Name | 2017 Compliance Review Score | # of CAPs Required | # of CAPs Closed | 2018 Final Follow-Up Review Score |
|---|---|---|---|---|---|
| I | Provider Selection | 100% | 0 | NA | **100%** |
| II | Subcontracts and Delegation | 100% | 0 | NA | **100%** |
| III | Credentialing | 93% | 6 | 6 | **100%** |
| IV | Quality Assessment and Performance Improvement | 100% | 0 | NA | **100%** |
| V | Health Information System | 100% | 0 | NA | **100%** |
| VI | Practice Guidelines | 100% | 0 | NA | **100%** |
| | **Totals** | **96%** | **6** | **6** | **100%** |

***NA*:** Not Applicable. Reevaluation was not necessary as the health plan achieved 100% for the standard.

### Strengths

Since 'Ohana QI performed well during the 2017 compliance review, only the *Credentialing* standard required corrective action items to be completed in 2018. To address the *Credentialing* standard deficiencies, 'Ohana QI developed a cover letter to notify credentialing applicants of their rights, provided training to all Credentialing staff to ensure organizational provider licenses are verified at initial credentialing and recredentialing, and updated the organizational provider policies and procedures to include the acceptable threshold for on-site quality assessments conducted by CMS or an approved survey agency and ensure that on-site quality assessments were performed on nonaccredited providers. 'Ohana QI also revised the credentialing policies and procedures to ensure complete Disclosure of Ownership forms were obtained at the time of recredentialing.

### Areas for Improvement

As a result of its CAP interventions, 'Ohana QI was found to be fully compliant with the *Credentialing* standard and had no continuing corrective actions.

# 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. 'Ohana QI was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that 'Ohana 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. 'Ohana QI elected to use nine standard and three nonstandard supplemental data sources for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2018 measure reporting. All convenience samples passed HSAG's review.

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

- HSAG recommended that 'Ohana QI ensures appropriate Roadmap documentation for supplemental data going forward.

'Ohana QI experienced no enrollment complications related to properly identifying these members on the daily and monthly enrollment files. Eligibility was properly identified within the Xcelys enrollment system. 'Ohana QI passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Prenatal and Postpartum Care—Postpartum Care*
- 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—*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- 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 3-35. None of the rates in this domain reported a relative improvement or decline of more than 10 percent in 2018. One measure rate (*Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older*) ranked at or above the national Medicaid 50th percentile but below the 75th percentile, with the remaining seven measure rates compared to benchmarks ranking below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2018.

**Table 3-35—'Ohana QI's HEDIS Results for QI Measures Under Access to Care**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adults' Access to Preventive/Ambulatory Health Services*** | | | | |
| *20–44 Years* | 60.74% | 59.33% | -2.32% | ★ |
| *45–64 Years* | 80.42% | 78.70% | -2.14% | ★ |
| *65 Years and Older* | 90.40% | 89.32% | -1.19% | ★★★ |
| *Total* | 74.57% | 72.57% | -2.68% | ★ |
| ***Children and Adolescents' Access to Primary Care Practitioners*** | | | | |
| *12–24 Months* | 89.95% | 91.27% | 1.47% | ★ |
| *25 Months–6 Years* | 72.32% | 77.87% | 7.67% | ★ |
| *7–11 Years* | 80.26% | 80.78% | 0.65% | ★ |
| *12–19 Years* | 79.79% | 77.05% | -3.43% | ★ |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment***[1] | | | | |
| *Initiation of AOD Treatment—Total—Total* | — | 48.42% | — | NC |
| *Engagement of AOD Treatment—Total—Total* | — | 15.04% | — | NC |

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Children's Preventive Health Performance Measure Results

'Ohana QI's Children's Preventive Health performance measure results are shown in Table 3-36. Twelve rates in this domain reported a relative improvement of more than 10 percent in 2018. However, only two measure rates ranked at or above the national Medicaid 50th percentile but below the 75th percentile. Conversely, 16 measure rates ranked below the national Medicaid 50th percentile, with 13 of these rates below the 25th percentile. Additionally, four measure rates demonstrated a relative decline in performance of more than 10 percent. There was one measure in this domain with MQD Quality Strategy targets for HEDIS 2018 (i.e., *Childhood Immunization Status—Combination 3*), and 'Ohana QI did not reach the established target, the 75th percentile.

**Table 3-36—'Ohana QI's HEDIS Results for QI Measures Under Children's Preventive Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adolescent Well-Care Visits*** | | | | |
| *Adolescent Well-Care Visits* | 29.68% | 39.17% | 31.97% | ★ |
| ***Childhood Immunization Status*** | | | | |
| *Combination 3* | 46.95% | 55.12% | 17.40% | ★ |
| *DTaP* | 52.25% | 61.75% | 18.18% | ★ |
| *Hepatitis B* | 62.33% | 71.08% | 14.04% | ★ |
| *HiB* | 66.31% | 73.80% | 11.30% | ★ |
| *IPV* | 63.93% | 71.39% | 11.67% | ★ |
| *MMR* | 68.70% | 76.51% | 11.37% | ★ |
| *Pneumococcal Conjugate* | 50.13% | 62.05% | 23.78% | ★ |
| *VZV* | 67.64% | 75.90% | 12.21% | ★ |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 40.97% | 34.83% | -14.99% | ★ |
| *Combination 2 (Meningococcal, Tdap, HPV)*[1] | — | 11.61% | — | NC |
| *HPV*[1] | — | 14.98% | — | NC |
| *Meningococcal* | 45.81% | 40.82% | -10.89% | ★ |
| *Tdap* | 45.37% | 38.95% | -14.15% | ★ |
| ***Well-Child Visits in the First 15 Months of Life*** | | | | |
| *No Well-Child Visits** | 3.87% | 1.90% | -50.90% | ★★ |
| *Six or More Well-Child Visits* | 53.04% | 65.08% | 22.70% | ★★★ |
| ***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* | 57.57% | 65.51% | 13.79% | ★ |
| ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | |
| *BMI Percentile—Total* | 85.40% | 72.93% | -14.60% | ★★★ |
| *Counseling for Nutrition—Total* | 61.80% | 62.93% | 1.83% | ★★ |
| *Counseling for Physical Activity—Total* | 52.55% | 50.73% | -3.46% | ★★ |

** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Women's Health Performance Measure Results

'Ohana QI's Women's Health performance measure results are shown in Table 3-37. One rate in this domain reported a relative decline in performance of more than 10 percent in 2018 (*Chlamydia Screening in Women—16–20 Years)*. All six measure rates compared to benchmarks ranked below the national Medicaid 50th percentile, with five of these rates below the 25th percentile. Conversely, one rate reported a relative improvement of more than 10 percent in 2018 (*Cervical Cancer Screening*). There were two measures[3-27] in this domain with MQD Quality Strategy targets for HEDIS 2018 (i.e., *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*). None of 'Ohana QI's measure rates met or exceeded the established MQD Quality Strategy targets.

**Table 3-37—'Ohana QI's HEDIS Results for QI Measures Under Women's Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Breast Cancer Screening***[1] | | | | |
| *Breast Cancer Screening* | — | 52.07% | — | NC |
| ***Cervical Cancer Screening*** | | | | |
| *Cervical Cancer Screening* | 44.04% | 51.82% | 17.67% | ★★ |
| ***Chlamydia Screening in Women*** | | | | |
| *16–20 Years* | 46.97% | 39.13% | -16.69% | ★ |
| *21–24 Years* | 56.15% | 54.62% | -2.72% | ★ |
| *Total* | 53.06% | 49.25% | -7.18% | ★ |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care* | 76.40% | 71.53% | -6.37% | ★ |
| *Postpartum Care* | 46.47% | 46.72% | 0.54% | ★ |

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Care for Chronic Conditions Performance Measure Results

'Ohana QI's Care for Chronic Conditions performance measure results are shown in Table 3-38. Five measure rates ranked at or above the national Medicaid 75th percentile but below the 90th percentile.

[3-27] The MQD Quality Strategy targets were established for three measures within the Women's Health domain: *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. Due to technical specification changes in 2018, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Breast Cancer Screening* measure.

Conversely, seven measure rates ranked below the national Medicaid 50th percentile, with one of these rates below the 25th percentile. Additionally, one rate reported a relative decline of more than 10 percent (*Comprehensive Diabetes Care—HbA1c Control [<7.0%]*). Eight measures[3-28] within this domain were associated with an MQD Quality Strategy target for HEDIS 2018, with 'Ohana QI meeting or exceeding the target for three measures (*Comprehensive Diabetes Care—Eye Exam [Retinal] Performed* and both *Medication Management for People With Asthma* rates).

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

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Annual Monitoring for Patients on Persistent Medications*** | | | | |
| *ACE Inhibitors or ARBs* | 91.61% | 91.63% | 0.02% | ★★★★ |
| *Diuretics* | 91.86% | 92.15% | 0.32% | ★★★★ |
| *Total*[1] | — | 91.80% | — | NC |
| ***Comprehensive Diabetes Care*** | | | | |
| *HbA1c Testing* | 85.32% | 85.90% | 0.68% | ★★ |
| *HbA1c Poor Control (>9.0%)** | 45.64% | 46.44% | 1.75% | ★★ |
| *HbA1c Control (<7.0%)* | 33.00% | 27.17% | -17.67% | ★ |
| *HbA1c Control (<8.0%)* | 45.93% | 44.04% | -4.11% | ★★ |
| *Eye Exam (Retinal) Performed* | 60.39% | 64.24% | 6.38% | ★★★★ |
| *Medical Attention for Nephropathy* | 89.53% | 89.68% | 0.17% | ★★ |
| *Blood Pressure Control (<140/90 mm Hg)* | 60.61% | 59.23% | -2.28% | ★★ |
| ***Controlling High Blood Pressure*** | | | | |
| *Controlling High Blood Pressure* | 55.58% | 54.55% | -1.85% | ★★ |
| ***Medication Management for People With Asthma*** | | | | |
| *Medication Compliance 50%—Total* | 65.70% | 69.91% | 6.41% | ★★★★ |
| *Medication Compliance 75%—Total* | 43.80% | 46.46% | 6.07% | ★★★★ |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

[3-28] Within this domain, there were 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).

## Behavioral Health Performance Measure Results

'Ohana QI's Behavioral Health performance measure results are shown in Table 3-39. Five rates in this domain reported a relative improvement in performance of more than 10 percent in 2018. Additionally, three measure rates ranked at or above the national Medicaid 50th percentile but below the 75th percentile. Conversely, the remaining six measure rates that were compared to benchmarks ranked below the national Medicaid 50th percentile, with two of these rates below the 25th percentile. The measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (*Follow-Up After Hospitalization for Mental Illness*) was not appropriate to compare to the established target, the 75th percentile, due to technical specification changes.

**Table 3-39—'Ohana QI's HEDIS Results for QI Measures Under Behavioral Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Antidepressant Medication Management***[1] | | | | |
| *Effective Acute Phase Treatment* | 48.19% | 51.26% | 6.37% | ★★ |
| *Effective Continuation Phase Treatment* | 35.32% | 34.71% | -1.73% | ★★ |
| ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*** | | | | |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | NA | 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% | 71.14% | -3.71% | ★ |
| ***Follow-Up After Emergency Department Visit for AOD Abuse or Dependence***[1] | | | | |
| *7-Day Follow-Up—13-17 Years* | NA | NA | — | NA |
| *7-Day Follow-Up—18+ Years* | 8.25% | 10.86% | 31.64% | ★★★ |
| *7-Day Follow-Up—Total* | 8.10% | 10.68% | 31.85% | ★★ |
| *30-Day Follow-Up—13-17 Years* | NA | NA | — | NA |
| *30-Day Follow-Up—18+ Years* | 14.86% | 17.74% | 19.38% | ★★★ |
| *30-Day Follow-Up—Total* | 14.58% | 17.43% | 19.55% | ★★★ |
| ***Follow-Up After Emergency Department Visit for Mental Illness***[1] | | | | |
| *7-Day Follow-Up* | 25.71% | 28.90% | 12.41% | ★ |
| *30-Day Follow-Up* | 43.22% | 45.89% | 6.18% | ★★ |
| ***Follow-Up After Hospitalization for Mental Illness***[2] | | | | |
| *7-Day Follow-Up* | — | 38.60% | — | NC |
| *30-Day Follow-Up* | — | 57.21% | — | NC |
| ***Follow-Up Care for Children Prescribed ADHD Medication***[1] | | | | |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Initiation Phase* | NA | NA | — | NA |
| *Continuation and Maintenance Phase* | NA | NA | — | NA |

*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## 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 3-40. With the exception of *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* and *Plan All-Cause Readmissions*, measure rates in this domain are presented for information only, as lower or higher rates are not indicative of performance. For the *Plan All-Cause Readmissions* measure, performance could not be compared to benchmarks because national benchmarks are not available for the Medicaid product line. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure failed to meet the MQD Quality Strategy target for HEDIS 2018, the 90th percentile.

**Table 3-40—'Ohana QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Ambulatory Care—Total (per 1,000 Member Months)*** | | | | |
| *ED Visits—Total** | 64.65 | 62.71 | -3.00% | ★★ |
| *Outpatient Visits—Total* | 502.90 | 570.59 | 13.46% | NC |
| ***Enrollment by Product Line—Total*** | | | | |
| *0–19 Years Subtotal Percentage—Total* | 22.62% | 23.91% | 5.70% | NC |
| *20–44 Years Subtotal Percentage—Total* | 33.32% | 34.22% | 2.70% | NC |
| *45–64 Years Subtotal Percentage—Total* | 28.78% | 27.92% | -2.99% | NC |
| *65+ Years Subtotal Percentage—Total* | 15.28% | 13.95% | -8.70% | NC |
| ***Inpatient Utilization—General Hospital/Acute Care—Total*** | | | | |
| *Maternity—Average Length of Stay—Total* | 2.65 | 2.70 | 1.89% | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Maternity—Days per 1,000 Member Months—Total* | 5.59 | 5.37 | -3.94% | NC |
| *Maternity—Discharges per 1,000 Member Months—Total* | 2.11 | 1.99 | -5.69% | NC |
| *Medicine—Average Length of Stay—Total* | 5.59 | 6.61 | 18.25% | NC |
| *Medicine—Days per 1,000 Member Months—Total* | 51.29 | 53.75 | 4.80% | NC |
| *Medicine—Discharges per 1,000 Member Months—Total* | 9.17 | 8.13 | -11.34% | NC |
| *Surgery—Average Length of Stay—Total* | 12.06 | 9.93 | -17.66% | NC |
| *Surgery—Days per 1,000 Member Months—Total* | 45.43 | 33.75 | -25.71% | NC |
| *Surgery—Discharges per 1,000 Member Months—Total* | 3.77 | 3.40 | -9.81% | NC |
| *Total Inpatient—Average Length of Stay—Total* | 6.97 | 7.05 | 1.15% | NC |
| *Total Inpatient—Days per 1,000 Member Months—Total* | 100.73 | 91.41 | -9.25% | NC |
| *Total Inpatient—Discharges per 1,000 Member Months—Total* | 14.45 | 12.97 | -10.24% | NC |
| ***Mental Health Utilization*** | | | | |
| *Any Service—Total*[1] | 14.28% | 14.07% | -1.47% | NC |
| *Inpatient—Total* | 1.03% | 0.60% | -41.75% | NC |
| *Intensive Outpatient or Partial Hospitalization—Total*[1] | 0.08% | 0.02% | -75.00% | NC |
| *Outpatient—Total*[2] | — | 13.09% | — | NC |
| *ED—Total*[2] | — | 0.37% | — | NC |
| *Telehealth—Total*[2] | — | 0.04% | — | NC |
| ***Plan All-Cause Readmissions*** | | | | |
| *Index Total Stays—Observed Readmissions—Ages 18-44** | — | 18.03% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 45-54** | — | 18.50% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 55-64** | — | 17.05% | — | NC |
| *Index Total Stays—Observed Readmissions—Total** | — | 17.73% | — | NC |

** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*

[2] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Conclusions and Recommendations

Based on HSAG's analyses of 'Ohana QI's 54 measure rates comparable to benchmarks, only 11 measure rates (20.4 percent) ranked at or above the national Medicaid 50th percentile, with five of these rates (9.3 percent) above the 75th percentile but below the 90th percentile, indicating positive performance in medication management of members with asthma, care for members with diabetes, and monitoring of members on persistent medications. Additionally, 'Ohana QI met three of the MQD Quality Strategy targets for HEDIS 2018: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*; and *Medication Management for People With Asthma—Medication Compliance 50%—Total* and *Medication Compliance 75%—Total*.

Conversely, 43 of 'Ohana QI's measure rates that were comparable to national benchmarks (79.6 percent) ranked below the national Medicaid 50th percentile, with 28 of these rates (51.9 percent) below the 25th percentile, 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—20–44 Years*, *45–64 Years*, and *Total*
  - *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- Children's Preventive Health
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status—Combination 3*, *DTaP*, *Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate*, and *VZV*
  - *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, *Meningococcal*, and *Tdap*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- Women's Health
  - *Chlamydia Screening in Women—16–20 Years*, *21–24 Years*, and *Total*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- Care for Chronic Conditions

  - *Comprehensive Diabetes Care—HbA1c Control (<7.0%)*
- Behavioral Health
  - *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

## Validation of Performance Improvement Projects

For validation year 2018, ‘Ohana QI submitted two state-mandated PIPs for validation—*Getting Needed Care* and *Improving Timeliness of Prenatal Care and Postpartum Care*. These rapid-cycle PIPs were implemented in June 2017. The PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

The *Getting Needed Care* PIP addressed CMS’ requirements related to quality outcomes—specifically, access to care and services. The focus of the PIP was to improve members’ satisfaction with access to appointments for check-ups or routine care and the ease of getting medical care. The targeted population consisted of members residing in Ewa Beach, Hilo, Honolulu, Waianae, and Waipahu.

The *Improving Timeliness of Prenatal Care and Postpartum Care* PIP addressed CMS’ requirements related to quality outcomes—specifically, access to and timeliness of care and services. The focus of the PIP was to increase the percentage of members who received timely prenatal and postpartum care visits. The targeted population included eligible women who reside in Honolulu, Waianae, Waipahu, Hilo, Kailua Kona, and Ewa Beach.

Table 3-41 outlines ‘Ohana QI’s SMART Aim for each PIP.

**Table 3-41—PIP Topic and SMART Aim Statements for ‘Ohana QI**

| PIP Topic | SMART Aim Statement |
|---|---|
| *Getting Needed Care* | By December 31, 2018, increase the rate of Getting Needed Care among members residing in Ewa Beach, Hilo, Honolulu, Waianae, and Waipahu from 75.8% to 84.2%. |
| *Improving Timeliness of Prenatal Care and Postpartum Care* | By December 31, 2018, ‘Ohana aims to increase the timeliness of prenatal care from 63% to 73% for pregnant members residing in Honolulu, Waianae, Waipahu, Ewa Beach, Kailua Kona, and Hilo.<br><br>By December 31, 2018, ‘Ohana aims to increase timeliness of postpartum care from 37% to 47% for members who delivered and reside in Honolulu, Waianae, Waipahu, Kailua Kona, Hilo, and Ewa Beach. |

## Findings

'Ohana QI successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2018 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2019 annual validation.

## Interventions

'Ohana QI is testing interventions using PDSA methodology through the SMART Aim end date of December 31, 2018. 'Ohana QI's intervention for the *Getting Needed Care* PIP involves using care gap coordinators to reach out to members and help them locate and schedule appointments with a provider.

'Ohana QI provided an update on intervention testing (Module 4) in June 2018 and October 2018. For the October 2018 update, HSAG provided feedback that the health plan should explain all data and include evaluation results for each component of the interventions.

For the *Improving Timeliness of Prenatal Care and Postpartum Care* PIP, 'Ohana QI's intervention for prenatal and postpartum care entails using care gap coordinators and/or patient care advocates to assist providers with scheduling member appointments, providing an online portal for navigation, providing transportation, and offering translation services through telephonic member outreach.

For the October 2018 update, HSAG provided feedback that the health plan should:

- Include monthly results for the intervention effectiveness measure.
- Calculate and report results according to the approved methodology.
- Make a final determination regarding interventions once testing is completed.

## Strengths and Weaknesses

'Ohana QI was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Getting Needed Care* and *Improving Timeliness of Prenatal Care and Postpartum Care* rapid-cycle PIPs.

## Recommendations for Improvement

Based on the 2018 PIP validation, HSAG recommended the following:

- 'Ohana QI should ensure that interventions are targeting and reaching a population large enough to impact the SMART Aim.
- The health plan should address all Module 4 pre-validation review and progress update feedback in the final submission of Module 4.

- 'Ohana QI should clearly link improvement in the SMART Aim to intervention(s) tested for the PIP. The health plan should report numerators, denominators, and percentage results at least monthly for the SMART Aim measure and intervention effectiveness measure(s).
- 'Ohana QI should work on completing the Module 5 submission form as the PIP progresses.
- 'Ohana QI should test an intervention until the SMART Aim end date, December 31, 2018.
- If the health plan needs to abandon an intervention, it should contact HSAG as soon as possible to discuss next steps.
- 'Ohana QI should use the PIP Reference Guide and contact HSAG as often as needed for technical assistance.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Satisfaction

### Findings

Table 3-42 presents the 2018 percentage of top-level responses for 'Ohana QI compared to the 2017 NCQA adult Medicaid national averages and the corresponding 2016 scores.[3-29,3-30,3-31] Additionally, the overall member satisfaction ratings (i.e., star ratings) resulting from 'Ohana QI's three-point mean scores compared to NCQA's HEDIS benchmarks are displayed below.[3-32]

**Table 3-42—Adult Medicaid CAHPS Results *for* 'Ohana QI**

| Measure | 2016 Scores | 2018 Scores | Star Ratings |
|---|---|---|---|
| **Global Ratings** | | | |
| Rating of Health Plan | 54.2% | 56.8% | ★★ |
| Rating of All Health Care | 52.9% | 54.3% | ★★★ |

[3-29] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI.
[3-30] The child population was last surveyed in 2017; therefore, the 2018 adult CAHPS scores are compared to the corresponding 2016 scores.
[3-31] National Committee for Quality Assurance. *HEDIS® 2018, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2017.
[3-32] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018.* Washington, DC: NCQA, August 20, 2018.

| Measure | 2016 Scores | 2018 Scores | Star Ratings |
|---|---|---|---|
| Rating of Personal Doctor | 68.3% | 66.8% | ★★★★★ |
| Rating of Specialist Seen Most Often | 67.1% | 71.1% | ★★★★★ |
| **Composite Measures** | | | |
| Getting Needed Care | 82.2% | 83.9% | ★★ |
| Getting Care Quickly | 84.2% | 81.8% | ★★ |
| How Well Doctors Communicate | 92.3% | 92.2% | ★★★★ |
| Customer Service | 85.6% | 87.1% | ★★ |
| Shared Decision Making | 82.0% | 83.9% | NA |
| **Individual Item Measures** | | | |
| Coordination of Care | 85.5% | 80.3% | ★ |
| Health Promotion and Education | 77.9% | 80.8% | NA |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA adult Medicaid national averages.
▲ indicates the 2018 score is statistically significantly higher than the 2016 score.
▼ indicates the 2018 score is statistically significantly lower than the 2016 score.
NA 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

## Strengths

For ‘Ohana QI’s adult Medicaid population, the following six measures met or exceeded the 2017 NCQA adult Medicaid national averages:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Health Promotion and Education*

In addition, the following two measures met or exceeded the 90th percentiles:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

Of the three MQD beneficiary satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—'Ohana QI's member satisfaction rating for *How Well Doctors Communicate* met or exceeded the 75th percentile.

### Areas for Improvement

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Coordination of Care*, *Getting Care Quickly*, and *Customer Service*. HSAG evaluated each of these areas to determine if specific 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," may be driving members' level of satisfaction with each of the priority areas; therefore, 'Ohana QI should consider determining whether potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-43 provides a summary of the key drivers identified for 'Ohana QI.

**Table 3-43—'Ohana QI Key Drivers of Satisfaction**

| Coordination of Care |
|---|
| Respondents reported that their 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. |
| **Getting Care Quickly** |
| Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one. |
| **Customer Service** |
| Respondents reported that the written materials or the Internet did not provide them with the information they needed about how their health plan works. |
| Respondents reported that their health plan's customer service did not always give them the information or help they needed. |

The following observations from the key drivers of satisfaction analysis indicate areas for improvement in access and timeliness for 'Ohana QI:

- Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.

The following observation from the key drivers of satisfaction analysis indicates an area for improvement in quality of care for 'Ohana QI:

- Respondents reported that their 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.

## Provider Survey

The following is a summary of the Provider Survey performance highlights for ‘Ohana QI. The performance highlights are broken into two key areas:

- Plan Comparison
- Trend Analysis

### Findings

Table 3-44 presents the 2018 top-box rates compared to the QI Program aggregate and the corresponding 2016 top-box rates, where applicable, on the six domains of satisfaction for ‘Ohana QI.[3-33]

**Table 3-44—Provider Survey Results for ‘Ohana QI**

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Plan Comparison Significance | Trend Analysis Significance |
|---|---|---|---|---|
| **General Positions** | | | | |
| Compensation Satisfaction | 16.1% | 18.7% | ↓ | — |
| Timeliness of Claims Payments | 25.7% | 31.3% | ↓ | — |
| **Providing Quality Care** | | | | |
| Prior Authorization Process | 9.6% | 15.6% | ↓ | — |
| Formulary | 10.4% | 14.1% | ↓ | — |
| **Non-Formulary** | | | | |
| Adequate Access to Non-Formulary Drugs | 4.4% | 24.1% | ↓ | — |
| **Service Coordinators** | | | | |
| Helpfulness of Service Coordinators | 14.5% | 19.8% | ↓ | — |
| **Specialists** | | | | |
| Adequacy of Specialists | 11.2% | 16.9% | ↓ | — |
| Adequacy of Behavioral Health Specialists | 7.6% | 6.6% | ↓ | — |
| Availability of Mental Health Providers | NA | 10.2% | ↓ | NT |

[3-33] For this report, only the top-box rates are displayed. For more detailed results on the other response categories, please see the 2018 Hawaii Provider Survey full report.

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Plan Comparison Significance | Trend Analysis Significance |
|---|---|---|---|---|
| **Substance Abuse** | | | | |
| Access to Substance Abuse Treatment | NA | 15.9% | ↓ | NT |

↑ *Indicates the QI health plan's 2018 top-box rate is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's 2018 top-box rate is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2018 top-box rate is statistically significantly higher than the 2016 top-box rate.*
▼ *Indicates the 2018 top-box rate is statistically significantly lower than the 2016 top-box rate.*
— *Indicates the QI health plan's 2018 top-box rate is not statistically significantly different than the QI Program aggregate or the 2018 top-box rate is not statistically significantly different than the 2016 top-box rate.*
*NA indicates that this measure was not included in the 2016 survey administration; therefore, 2016 top-box rates are not available.*
*NT indicates that this measure was not included in the 2016 survey administration; therefore, the results for this measure are not trendable.*

### Strengths

Based on ‘Ohana QI’s performance, no measurement areas were identified as an area of strength.

### Areas for Improvement

For ‘Ohana QI, all 10 measures scored statistically significantly lower than the QI Program aggregate:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Prior Authorization Process*
- *Formulary*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Service Coordinators*
- *Adequacy of Specialists*
- *Adequacy of Behavioral Health Specialists*
- *Availability of Mental Health Providers*
- *Access to Substance Abuse Treatment*

## *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 illustrated poor performance across the five EQR activities. While follow-up on compliance monitoring review findings indicated that ‘Ohana QI continued to improve its operational foundation to support the quality, access, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

Since ‘Ohana QI performed moderately well during the 2017 compliance review, only six corrective action items needed to be addressed in 2018. Encompassing the *Credentialing* standard, ‘Ohana QI took the necessary steps to ensure its policies and procedures were updated to ensure providers are advised of their rights, identify an acceptable threshold for on-site assessments, acquisition of Disclosure of Ownership forms, and training ‘Ohana QI staff on changes. As a result, ‘Ohana QI continued to show that it had 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, despite a strong infrastructure, health plan performance indicators and member satisfaction scores were generally below the national Medicaid 50th percentile.

Overall, more than three-quarters (80 percent) of ‘Ohana QI’s measures fell below the NCQA national Medicaid 50th percentile across all domains, with 52 percent of the measure rates falling below the 25th percentile. While some measures showed improvement from 2017, ‘Ohana QI’s performance highlighted the need to improve process and outcomes across all measure domains. In particular, ‘Ohana QI should address performance in the *Access to Care, Children’s Preventive Health, Women’s Health,* and *Utilization* domains where more than 75 percent of the measure rates were below the 50th percentile. Overall, only three of the MQD’s 12 Quality Strategy targets were met in 2018.

Similarly, ‘Ohana QI’s CAHPS results illustrated opportunities for improvement in members’ satisfaction. While none of the measures scored statistically significantly lower in 2018 than in 2016, the following five measure rates were below the 50th percentiles: *Rating of Health Plan, Getting Needed Care, Getting Care Quickly, Customer Service*, and *Coordination of Care*. Additionally, five of the 11 measures scored below the 2017 NCQA adult Medicaid national averages: *Rating of Health Plan, Rating of All Health Care, Getting Care Quickly, Customer Service*, and *Coordination of Care*. Moreover, ‘Ohana QI’s Provider Survey results suggested that its providers expressed significantly lower satisfaction across all measurement areas compared to the QI aggregate.

Finally, although final results for ‘Ohana QI’s PIPs were not available in 2018, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Getting Needed Care* and *Improving Timeliness of Prenatal Care and Postpartum Care* rapid-cycle PIPs.

# UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

## *Compliance Monitoring Review*

The 2018 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2017 review.

### Findings

Table 3-45 presents the scores from HSAG's 2017 compliance review, the number of CAPs required, and the results of the 2018 follow-up reviews of UHC CP QI.

**Table 3-45—Standards and Compliance Scores—UHC CP QI**

| Standard # | Standard Name | 2017 Compliance Review Score | # of CAPs Required | # of CAPs Closed | 2018 Final Follow-Up Review Score |
|---|---|---|---|---|---|
| I | Provider Selection | 100% | 0 | NA | **100%** |
| II | Subcontracts and Delegation | 100% | 0 | NA | **100%** |
| III | Credentialing | 91% | 7 | 7 | **100%** |
| IV | Quality Assessment and Performance Improvement | 100% | 0 | NA | **100%** |
| V | Health Information System | 100% | 0 | NA | **100%** |
| VI | Practice Guidelines | 100% | 0 | NA | **100%** |
| | **Totals** | **95%** | **7** | **7** | **100%** |

***NA*:** Not Applicable. Reevaluation was not necessary as the health plan achieved 100% for the standard.

### Strengths

Since UHC CP QI performed well during the 2017 compliance review, only the *Credentialing* standard required corrective action items to be completed in 2018. To address the *Credentialing* standard deficiencies, UHC CP QI revised its credentialing policies and procedures to clearly describe the credentialing process, correct inconsistencies between the national policies and the local health plan policies, and establish the acceptable threshold for on-site quality assessments conducted by CMS or an approved survey agency. To ensure that its delegates' credentialing and recredentialing files are audited annually against NCQA standards, UHC CP QI created a standard operating procedure to ensure that Hawaii-specific files are included in the national annual credentialing file audit.

### Areas for Improvement

As a result of its CAP interventions, UHC CP QI was found to be fully compliant with the *Credentialing* standard and had no continuing corrective actions.

# 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. UHC CP QI was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that UHC CP 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. UHC CP QI elected to use four standard and five nonstandard supplemental data sources for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2018 measure reporting. All convenience samples passed HSAG's review.

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 the Facets enrollment system. UHC CP QI passed the MRRV process for the following measure groups:

- Group A: Biometrics (BMI, BP) & Maternity—*Controlling High Blood Pressure (CBP)*
- Group B: Anticipatory Guidance & Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—*WCC—Counseling for Nutrition*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Control (<7.0%)*
- Group D: Immunization & Other Screenings—*IMA Combo 2*
- 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 3-46. None of the rates in this domain reported a relative improvement or decline of more than 10 percent in 2018. One measure rate (*Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older*) ranked at or above the national Medicaid 90th percentile. Conversely, the remaining seven measure rates ranked below the national Medicaid 50th percentile, with five of these rates below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2018.

**Table 3-46—UHC CP QI's HEDIS Results for QI Measures Under Access to Care**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adults' Access to Preventive/Ambulatory Health Services*** | | | | |
| *20–44 Years* | 58.08% | 57.68% | -0.69% | ★ |
| *45–64 Years* | 79.37% | 79.40% | 0.04% | ★ |
| *65 Years and Older* | 94.46% | 94.77% | 0.33% | ★★★★★ |
| *Total* | 76.01% | 76.83% | 1.08% | ★★ |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Children and Adolescents' Access to Primary Care Practitioners*** | | | | |
| *12–24 Months* | 91.55% | 93.61% | 2.25% | ★★ |
| *25 Months–6 Years* | 74.73% | 78.90% | 5.58% | ★ |
| *7–11 Years* | 82.46% | 80.89% | -1.90% | ★ |
| *12–19 Years* | 79.34% | 79.08% | -0.33% | ★ |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment***[1] | | | | |
| *Initiation of AOD Treatment—Total—Total* | — | 38.62% | — | NC |
| *Engagement of AOD Treatment—Total—Total* | — | 11.38% | — | NC |

*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Children's Preventive Health Performance Measure Results

UHC CP QI's Children's Preventive Health performance measure results are shown in Table 3-47. Eight rates in this domain reported a relative improvement of more than 10 percent in 2018. Additionally, four measure rates ranked at or above the national Medicaid 50th percentile, with two of these rates at or above the 75th percentile but below the 90th percentile. Conversely, 13 measure rates ranked below the national Medicaid 25th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (i.e., *Childhood Immunization Status—Combination 3*), and UHC CP QI did not reach the established target, the 75th percentile.

**Table 3-47—UHC CP QI's HEDIS Results for QI Measures Under Children's Preventive Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adolescent Well-Care Visits*** | | | | |
| *Adolescent Well-Care Visits* | 36.98% | 45.74% | 23.69% | ★★ |
| ***Childhood Immunization Status*** | | | | |
| *Combination 3* | 55.65% | 60.22% | 8.21% | ★ |
| *DTaP* | 60.33% | 67.51% | 11.90% | ★ |
| *Hepatitis B* | 76.86% | 82.07% | 6.78% | ★ |
| *HiB* | 77.41% | 83.47% | 7.83% | ★ |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *IPV* | 76.58% | 80.95% | 5.71% | ★ |
| *MMR* | 76.58% | 78.99% | 3.15% | ★ |
| *Pneumococcal Conjugate* | 60.33% | 67.23% | 11.44% | ★ |
| *VZV* | 74.66% | 78.71% | 5.42% | ★ |
| ***Immunizations for Adolescents*** | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 34.38% | 49.15% | 42.96% | ★ |
| *Combination 2 (Meningococcal, Tdap, HPV)*[1] | — | 20.09% | — | NC |
| *HPV*[1] | — | 23.50% | — | NC |
| *Meningococcal* | 37.50% | 54.27% | 44.72% | ★ |
| *Tdap* | 40.10% | 54.70% | 36.41% | ★ |
| ***Well-Child Visits in the First 15 Months of Life*** | | | | |
| *No Well-Child Visits** | 4.11% | 3.50% | -14.84% | ★ |
| *Six or More Well-Child Visits* | 61.88% | 70.70% | 14.25% | ★★★★ |
| ***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* | 61.07% | 61.12% | 0.08% | ★ |
| ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | |
| *BMI Percentile—Total* | 79.32% | 83.29% | 5.01% | ★★★★ |
| *Counseling for Nutrition—Total* | 65.21% | 69.83% | 7.08% | ★★★ |
| *Counseling for Physical Activity—Total* | 58.64% | 62.59% | 6.74% | ★★★ |

** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Women's Health Performance Measure Results

UHC CP QI's Women's Health performance measure results are shown in Table 3-48. None of the rates in this domain reported a relative improvement or decline of more than 10 percent in 2018. All six measure rates compared to benchmarks ranked below the national Medicaid 50th percentile, with three

of these rates below the 25th percentile. There were two measures[3-34] in this domain with MQD Quality Strategy targets for HEDIS 2018 (i.e., *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*). None of UHC CP QI's measure rates met or exceeded the established MQD Quality Strategy targets.

**Table 3-48—UHC CP QI's HEDIS Results for QI Measures Under Women's Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Breast Cancer Screening***[1] | | | | |
| *Breast Cancer Screening* | — | 62.06% | — | NC |
| ***Cervical Cancer Screening*** | | | | |
| *Cervical Cancer Screening* | 43.80% | 47.45% | 8.33% | ★ |
| ***Chlamydia Screening in Women*** | | | | |
| *16–20 Years* | 50.31% | 47.93% | -4.73% | ★★ |
| *21–24 Years* | 55.90% | 59.56% | 6.55% | ★★ |
| *Total* | 54.26% | 55.85% | 2.93% | ★★ |
| ***Prenatal and Postpartum Care*** | | | | |
| *Timeliness of Prenatal Care* | 78.80% | 73.11% | -7.22% | ★ |
| *Postpartum Care* | 54.97% | 52.32% | -4.82% | ★ |

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Care for Chronic Conditions Performance Measure Results

UHC CP QI's Care for Chronic Conditions performance measure results are shown in Table 3-49. Two rates in this domain reported a relative improvement of more than 10 percent in 2018 (*Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]* and *Medication Management for People With Asthma—Medication Compliance 75%—Total*). Additionally, seven measure rates ranked at or above the national Medicaid 75th percentile, with two of these rates above the 90th percentile. Conversely, one measure rate (*Comprehensive Diabetes Care—HbA1c Control (<7.0%)*) ranked below the national Medicaid

[3-34] The MQD Quality Strategy targets were established for three measures within the Women's Health domain: *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. Due to technical specification changes in 2018, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Breast Cancer Screening* measure.

50th percentile. There were eight measures[3-35] within this domain associated with an MQD Quality Strategy target for HEDIS 2018, with UHC CP QI meeting or exceeding the target for four measures (three *Comprehensive Diabetes Care* indicators and *Medication Management for People With Asthma—Medication Compliance 75%—Total*).

**Table 3-49—UHC CP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Annual Monitoring for Patients on Persistent Medications*** | | | | |
| *ACE Inhibitors or ARBs* | 91.80% | 92.93% | 1.23% | ★★★★★ |
| *Diuretics* | 91.88% | 93.81% | 2.10% | ★★★★★ |
| *Total*[1] | — | 93.20% | — | NC |
| ***Comprehensive Diabetes Care*** | | | | |
| *HbA1c Testing* | 86.64% | 88.24% | 1.85% | ★★★ |
| *HbA1c Poor Control (>9.0%)** | 38.48% | 33.86% | -12.01% | ★★★★ |
| *HbA1c Control (<7.0%)* | 32.75% | 35.67% | 8.92% | ★★ |
| *HbA1c Control (<8.0%)* | 50.72% | 54.93% | 8.30% | ★★★★ |
| *Eye Exam (Retinal) Performed* | 69.60% | 67.41% | -3.15% | ★★★★ |
| *Medical Attention for Nephropathy* | 91.36% | 92.85% | 1.63% | ★★★★ |
| *Blood Pressure Control (<140/90 mm Hg)* | 65.20% | 68.04% | 4.36% | ★★★ |
| ***Controlling High Blood Pressure*** | | | | |
| *Controlling High Blood Pressure* | 61.98% | 63.78% | 2.90% | ★★★ |
| ***Medication Management for People With Asthma*** | | | | |
| *Medication Compliance 50%—Total* | 63.45% | 62.89% | -0.88% | ★★★ |
| *Medication Compliance 75%—Total* | 40.61% | 45.88% | 12.98% | ★★★★ |

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*
** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

[3-35] Within this domain, there were 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).

## Behavioral Health Performance Measure Results

UHC CP QI's Behavioral Health performance measure results are shown in Table 3-50. Overall, four measure rates ranked at or above the national Medicaid 50th percentile but below the 75th percentile. Conversely, the remaining five measure rates compared to benchmarks ranked below the national Medicaid 50th percentile, with one of these rates below the 25th percentile. Additionally, six measure rates in this domain reported a relative decline of more than 10 percent in 2018. The measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (*Follow-Up After Hospitalization for Mental Illness*) was not appropriate to compare to the established target, the 75th percentile, due to technical specification changes.

**Table 3-50—UHC CP QI's HEDIS Results for QI Measures Under Behavioral Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Antidepressant Medication Management***[1] | | | | |
| *Effective Acute Phase Treatment* | 52.38% | 52.37% | -0.02% | ★★★ |
| *Effective Continuation Phase Treatment* | 39.38% | 37.26% | -5.38% | ★★★ |
| ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*** | | | | |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | NA | 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% | 75.68% | -3.25% | ★ |
| ***Follow-Up After Emergency Department Visit for AOD Abuse or Dependence*** | | | | |
| *7-Day Follow-Up—13-17 Years* | NA | NA | — | NA |
| *7-Day Follow-Up—18+ Years* | 28.07% | 8.53% | -69.61% | ★★ |
| *7-Day Follow-Up—Total* | 28.02% | 8.64% | -69.16% | ★★ |
| *30-Day Follow-Up—13-17 Years* | NA | NA | — | NA |
| *30-Day Follow-Up—18+ Years* | 33.40% | 16.63% | -50.21% | ★★★ |
| *30-Day Follow-Up—Total* | 33.47% | 16.63% | -50.31% | ★★★ |
| ***Follow-Up After Emergency Department Visit for Mental Illness*** | | | | |
| *7-Day Follow-Up* | 64.01% | 32.41% | -49.37% | ★★ |
| *30-Day Follow-Up* | 72.10% | 52.24% | -27.55% | ★★ |
| ***Follow-Up After Hospitalization for Mental Illness***[2] | | | | |
| *7-Day Follow-Up* | — | 50.62% | — | NC |
| *30-Day Follow-Up* | — | 61.73% | — | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Follow-Up Care for Children Prescribed ADHD Medication***[1] | | | | |
| *Initiation Phase* | NA | NA | — | NA |
| *Continuation and Maintenance Phase* | NA | NA | — | NA |

*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*BR indicates that the rate was materially biased.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## 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 3-51. With the exception of *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* and *Plan All-Cause Readmissions*, measure rates in this domain are presented for information only, as lower or higher rates are not indicative of performance. For the *Plan All-Cause Readmissions* measure, performance could not be compared to benchmarks because national benchmarks are not available for the Medicaid product line. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure failed to meet the MQD Quality Strategy target for HEDIS 2018, the 90th percentile.

**Table 3-51—UHC CP QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Ambulatory Care—Total (per 1,000 Member Months)*** | | | | |
| *ED Visits—Total** | 61.01 | 51.89 | -14.95% | ★★★★ |
| *Outpatient Visits—Total* | 556.18 | 460.05 | -17.28% | NC |
| ***Enrollment by Product Line—Total*** | | | | |
| *0–19 Years Subtotal Percentage—Total* | 20.53% | 20.37% | -0.78% | NC |
| *20–44 Years Subtotal Percentage—Total* | 32.47% | 31.47% | -3.08% | NC |
| *45–64 Years Subtotal Percentage—Total* | 25.53% | 24.81% | -2.82% | NC |
| *65+ Years Subtotal Percentage—Total* | 21.47% | 23.35% | 8.76% | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Inpatient Utilization—General Hospital/Acute Care—Total*** | | | | |
| *Maternity—Average Length of Stay—Total* | 2.48 | 2.89 | 16.53% | NC |
| *Maternity—Days per 1,000 Member Months—Total* | 4.29 | 5.82 | 35.66% | NC |
| *Maternity—Discharges per 1,000 Member Months—Total* | 1.73 | 2.01 | 16.18% | NC |
| *Medicine—Average Length of Stay—Total* | 5.41 | 5.79 | 7.02% | NC |
| *Medicine—Days per 1,000 Member Months—Total* | 27.62 | 38.25 | 38.49% | NC |
| *Medicine—Discharges per 1,000 Member Months—Total* | 5.11 | 6.61 | 29.35% | NC |
| *Surgery—Average Length of Stay—Total* | 10.57 | 10.23 | -3.22% | NC |
| *Surgery—Days per 1,000 Member Months—Total* | 28.72 | 32.45 | 12.99% | NC |
| *Surgery—Discharges per 1,000 Member Months—Total* | 2.72 | 3.17 | 16.54% | NC |
| *Total Inpatient—Average Length of Stay—Total* | 6.60 | 6.72 | 1.82% | NC |
| *Total Inpatient—Days per 1,000 Member Months—Total* | 59.20 | 74.48 | 25.81% | NC |
| *Total Inpatient—Discharges per 1,000 Member Months—Total* | 8.97 | 11.09 | 23.63% | NC |
| ***Mental Health Utilization*** | | | | |
| *Any Service—Total*[1] | 11.71% | 11.49% | -1.88% | NC |
| *Inpatient—Total* | 0.58% | 0.55% | -5.17% | NC |
| *Intensive Outpatient or Partial Hospitalization—Total*[1] | 0.03% | 0.17% | 466.67% | NC |
| *Outpatient—Total*[2] | — | 10.84% | — | NC |
| *ED—Total*[2] | — | 0.08% | — | NC |
| *Telehealth—Total*[2] | — | 0.02% | — | NC |
| ***Plan All-Cause Readmissions*** | | | | |
| *Index Total Stays—Observed Readmissions—Ages 18-44** | — | 12.25% | — | NC |
| *Index Total Stays—Observed Readmissions—Ages 45-54** | — | 17.44% | — | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Index Total Stays—Observed Readmissions—Ages 55-64** | — | 17.62% | — | NC |
| *Index Total Stays—Observed Readmissions—Total** | — | 16.08% | — | NC |

** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Conclusions and Recommendations

Based on HSAG's analyses of UHC CP QI's 54 measure rates comparable to benchmarks, 21 measure rates (38.9 percent) ranked at or above the national Medicaid 50th percentile, with 11 of these rates (20.4 percent) above the 75th percentile, indicating positive performance in several areas, including well-child visits for young children, BMI percentile documentation for children and adolescents, medication management for members with asthma, care for members with diabetes, and monitoring of members on persistent medications. Additionally, UHC CP QI met four of the MQD Quality Strategy targets for HEDIS 2018: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*; and *Medication Management for People With Asthma—Medication Compliance 75%—Total*.

Conversely, 33 of UHC CP QI's measure rates that were comparable to national benchmarks (61.1 percent) ranked below the national Medicaid 50th percentile, with 22 of these rates (40.7 percent) below the 25th percentile, 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—20–44 Years* and *45–64 Years*
  - *Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- Children's Preventive Health
  - *Childhood Immunization Status—Combination 3*, *DTaP*, *Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate*, and *VZV*

  - *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap), Meningococcal*, and *Tdap*
  - *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*
  - *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*
- Women's Health
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- Behavioral Health
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

## Validation of Performance Improvement Projects

For validation year 2018, UHC CP QI submitted two state-mandated PIPs for validation—*Getting Needed Care: Improving Access to Behavioral Health Services* and *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County*. These rapid-cycle PIPs were implemented in June 2017. The PIP topics represent key areas of focus for improvement and are part of the MQD quality strategy.

The *Getting Needed Care: Improving Access to Behavioral Health Services* PIP addressed CMS' requirements related to quality outcomes—specifically, access to care and services. The focus of the PIP was to improve health plan members' perception with ease of access to a behavioral health specialist appointment as soon as the member felt he or she needed it.

*The Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* PIP addressed CMS' requirements related to quality outcomes—specifically, access to and timeliness of care and services. The focus of the PIP was to increase the percentage of members who received timely prenatal and postpartum care visits. The targeted population included eligible women located in Hawai'i County.

Table 3-52 outlines UHC CP QI's SMART Aim Statement for each PIP.

**Table 3-52—PIP Topic and SMART Aim Statements for UHC CP QI**

| PIP Topic | SMART Aim Statement |
|---|---|
| *Getting Needed Care: Improving Access to Behavioral Health Services* | By December 31, 2018, increase the rate of ease of access to a mental health specialist appointment as soon as the member felt they [he or she] needed, from 57.46% to 61.46%. |
| *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* | By December 31, 2018, UHC CP aims to increase the timeliness of prenatal care hybrid rates from 76.6% to 79.6% and timeliness of postpartum care hybrid rates from 46.8% to 49.8% among members located in Hawai'i County. |

## Findings

UHC CP QI successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2018 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2019 annual validation.

## Interventions

UHC CP QI is testing interventions using PDSA methodology through the SMART Aim end date of December 31, 2018. UHC CP QI's intervention for the *Getting Needed Care: Improving Access to Behavioral Health Services* PIP involves expanding the existing member services call center training to include further instruction on the behavioral health provider types. Additionally, the health plan is training the member services department and primary care providers about telehealth.

UHC CP QI provided an update on intervention testing (Module 4) in May 2018, June 2018, and October 2018. For the October 2018 update, HSAG provided feedback that the health plan should ensure that it provides all intervention effectiveness measure data in the Module 4 results.

For the *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* PIP, UHC CP QI's intervention for prenatal and postpartum care involves partnering with providers to identify women early in their pregnancy. Members will be contacted to inform them of health plan coverage and to address barriers to attending the appointments. Additionally, for prenatal care, the health plan is partnering with the Women, Infants, and Children (WIC) Program to identify members who are pregnant. For postpartum care, UHC CP QI is offering a member rewards program to actively engage and provide incentives to those members prone to no-show. For the October 2018 update, HSAG provided feedback that the health plan should provide monthly intervention effectiveness measure data in accordance with HSAG's feedback on the Module 4 intervention plan submitted to HSAG in March 2018.

## Strengths and Weaknesses

UHC CP QI was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Getting Needed Care: Improving Access to Behavioral Health Services* and *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* rapid-cycle PIPs.

## Recommendations for Improvement

Based on the 2018 PIP validation, HSAG recommended the following:

- If UHC CP QI tests interventions that were not originally included in Module 3, the health plan should submit a Module 4 plan for pre-validation review and update the intervention determination table in the final Module 5 submission.

- UHC CP QI should define all intervention effectiveness measures appropriately to measure the impact of interventions.
- The health plan should address all Module 4 pre-validation review and progress update feedback in the final submission of Module 4.
- UHC CP QI should clearly link improvement in the SMART Aim to intervention(s) tested for the PIP. The health plan should report numerators, denominators, and percentage results at least monthly for the SMART Aim measure and intervention effectiveness measure(s).
- UHC CP QI should work on completing the Module 5 submission form as the PIP progresses.
- UHC CP QI should test an intervention until the SMART Aim end date, December 31, 2018.
- If the health plan needs to abandon an intervention, it should contact HSAG as soon as possible to discuss next steps.
- UHC CP QI should use the PIP Reference Guide and contact HSAG as often as needed for technical assistance.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Satisfaction

### Findings

Table 3-53 presents the 2018 percentage of top-level responses for UHC CP QI compared to the 2017 NCQA adult Medicaid national averages and the corresponding 2016 scores.[3-36,3-37,3-38] Additionally, the overall member satisfaction ratings (i.e., star ratings) resulting from UHC CP QI's three-point mean scores compared to NCQA's HEDIS benchmarks are displayed below.[3-39]

[3-36] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI.
[3-37] The child population was last surveyed in 2017; therefore, the 2018 adult CAHPS scores are compared to the corresponding 2016 scores.
[3-38] National Committee for Quality Assurance. *HEDIS® 2018, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2017.
[3-39] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018.* Washington, DC: NCQA, August 20, 2018.

**Table 3-53—Adult Medicaid CAHPS Results *for* UHC CP QI**

| Measure | 2016 Scores | 2018 Scores | Star Ratings |
|---|---|---|---|
| **Global Ratings** | | | |
| Rating of Health Plan | 60.0% | 63.0% | ★★★★ |
| Rating of All Health Care | 56.0% | 55.0% | ★★★ |
| Rating of Personal Doctor | 64.8% | 66.2% | ★★★★★ |
| Rating of Specialist Seen Most Often | 70.9% | 66.8% | ★★★★★ |
| **Composite Measures** | | | |
| Getting Needed Care | 80.5% | 83.1% | ★★★ |
| Getting Care Quickly | 77.9% | 85.2% ▲ | ★★★ |
| How Well Doctors Communicate | 90.1% | 93.2% | ★★★★★ |
| Customer Service | 89.1% | 88.0% | ★★ |
| Shared Decision Making | 81.8% | 82.9% | NA |
| **Individual Item Measures** | | | |
| Coordination of Care | 84.0% | 82.3% | ★★ |
| Health Promotion and Education | 76.3% | 77.2% | NA |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA adult Medicaid national averages.
▲ indicates the 2018 score is statistically significantly higher than the 2016 score.
▼ indicates the 2018 score is statistically significantly lower than the 2016 score.
NA 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

## Strengths

For UHC CP QI's adult Medicaid population, the following seven measures met or exceeded the 2017 NCQA adult Medicaid national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Health Promotion and Education*

In addition, the following one measure scored statistically significantly higher in 2018 than in 2016:

- *Getting Care Quickly*

Also, the following three measures met or exceeded the 90th percentiles:

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*

Of the three MQD beneficiary satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—UHC CP QI's member satisfaction ratings for *Rating of Health Plan* and *How Well Doctors Communicate* met or exceeded the 75th percentile.

### Areas for Improvement

Based on a comprehensive assessment of the QI Program's CAHPS results, three potential areas for quality improvement were identified: *Customer Service, Coordination of Care,* and *Getting Needed Care*. HSAG evaluated each of these areas to determine if specific 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," may be driving members' level of satisfaction with each of the priority areas; therefore, UHC CP QI should consider determining whether potential quality improvement activities could improve member satisfaction on each of the key drivers identified. Table 3-54 provides a summary of the key drivers identified for UHC CP QI.

**Table 3-54—UHC CP QI Key Drivers of Satisfaction**

| Customer Service |
|---|
| Respondents reported that their health plan's customer service did not always give them the information or help they needed. |
| Respondents reported that forms from their health plan were often not easy to fill out. |
| **Coordination of Care** |
| Respondents reported that their personal doctor did not always listen to them. |
| **Getting Needed Care** |
| Respondents reported that it was often not easy for them to obtain appointments with specialists. |
| Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one. |

The following observations from the key drivers of satisfaction analysis indicate areas for improvement in access and timeliness for UHC CP QI:

- Respondents reported that it was often not easy for them to obtain appointments with specialists.
- Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.

The following observation from the key drivers of satisfaction analysis indicates an area for improvement in quality of care for UHC CP QI:

- Respondents reported that their personal doctor did not always listen to them.

## Provider Survey

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

- Plan Comparison
- Trend Analysis

### Findings

Table 3-55 presents the 2018 top-box rates compared to the QI Program aggregate and the corresponding 2016 top-box rates, where applicable, on the six domains of satisfaction for UHC CP QI.[3-40]

**Table 3-55—Provider Survey Results for UHC CP QI**

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Plan Comparison Significance | Trend Analysis Significance |
|---|---|---|---|---|
| **General Positions** | | | | |
| Compensation Satisfaction | 18.6% | 24.6% | ↓ | — |
| Timeliness of Claims Payments | 31.5% | 34.8% | ↓ | — |
| **Providing Quality Care** | | | | |
| Prior Authorization Process | 9.5% | 14.8% | ↓ | — |
| Formulary | 13.2% | 17.3% | ↓ | — |
| **Non-Formulary** | | | | |
| Adequate Access to Non-Formulary Drugs | 6.3% | 20.8% | ↓ | — |
| **Service Coordinators** | | | | |
| Helpfulness of Service Coordinators | 16.6% | 22.3% | ↓ | — |
| **Specialists** | | | | |
| Adequacy of Specialists | 9.8% | 20.7% | ↓ | — |

[3-40] For this report, only the top-box rates are displayed. For more detailed results on the other response categories, please see the 2018 Hawaii Provider Survey full report.

| | 2016 Top-Box Rate | 2018 Top-Box Rate | Plan Comparison Significance | Trend Analysis Significance |
|---|---|---|---|---|
| Adequacy of Behavioral Health Specialists | 5.6% | 6.6% | ↓ | — |
| Availability of Mental Health Providers | NA | 10.1% | ↓ | NT |
| **Substance Abuse** | | | | |
| Access to Substance Abuse Treatment | NA | 18.1% | ↓ | NT |

↑ *Indicates the QI health plan's 2018 top-box rate is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's 2018 top-box rate is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2018 top-box rate is statistically significantly higher than the 2016 top-box rate.*
▼ *Indicates the 2018 top-box rate is statistically significantly lower than the 2016 top-box rate.*
— *Indicates the QI health plan's 2018 top-box rate is not statistically significantly different than the QI Program aggregate or the 2018 top-box rate is not statistically significantly different than the 2016 top-box rate.*
*NA indicates that this measure was not included in the 2016 survey administration; therefore, 2016 top-box rates are not available.*
*NT indicates that this measure was not included in the 2016 survey administration; therefore, the results for this measure are not trendable.*

### Strengths

Based on UHC CP QI's performance, no measurement areas were identified as an area of strength.

### Areas for Improvement

For UHC CP QI, all 10 measures scored statistically significantly lower than the QI Program aggregate:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Prior Authorization Process*
- *Formulary*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Service Coordinators*
- *Adequacy of Specialists*
- *Adequacy of Behavioral Health Specialists*
- *Availability of Mental Health Providers*
- *Access to Substance Abuse Treatment*

## *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 illustrated poor performance across the five EQR activities. While follow-up on compliance monitoring review findings indicated that UHC CP QI continued to improve its operational foundation to support the quality, access, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

Since UHC CP QI performed moderately well during the 2017 compliance review, only seven corrective action items needed to be addressed in 2018. Focused on the *Credentialing* standard, UHC CP QI took the necessary steps to ensure its policies and procedures were updated to address inconsistencies between national and local health plan policies. As a result, UHC CP QI continued to show that it had 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, despite a strong infrastructure, health plan performance indicators and member satisfaction scores were frequently below the national Medicaid 50th percentile.

Overall, just under two-thirds (61 percent) of UHC CP QI's measure rates fell below the NCQA national Medicaid 50th percentile across all domains, with 41 percent of the measure rates falling below the 25th percentile. While some measures showed improvement from 2017, UHC CP QI's performance highlighted the need to improve process and outcomes across most measure domains. In particular, UHC CP QI should address performance in the *Access to Care*, *Children's Preventive Health,* and *Women's Health* domains where more than 75 percent of the measure rates were below the 50th percentile. Overall, only four of the MQD's 12 Quality Strategy targets were met in 2018.

Similarly, UHC CP QI's CAHPS results illustrated opportunities for improvement in members' satisfaction. While none of the measures scored statistically significantly lower in 2018 than in 2016, the following two measure rates were below the 50th percentiles: *Customer Service* and *Coordination of Care*. Additionally, four of the 11 measures scored below the 2017 NCQA adult Medicaid national averages: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Customer Service*, and *Coordination of Care*. Moreover, UHC CP QI's Provider Survey results suggested that its providers expressed significantly lower satisfaction across all measurement areas compared to the QI aggregate.

Finally, although final results for UHC CP QI's PIPs were not available in 2018, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Getting Needed Care: Improving Access to Behavioral Health Services* and *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* rapid-cycle PIPs.

# 'Ohana Community Care Services ('Ohana CCS) Results

## *Compliance Monitoring Review*

The 2018 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2017 review.

### Findings

Table 3-56 presents the scores from HSAG's 2017 compliance review, the number of CAPs required, and the results of the 2018 follow-up reviews of 'Ohana CCS.

**Table 3-56—Standards and Compliance Scores—'Ohana CCS**

| Standard # | Standard Name | 2017 Compliance Review Score | # of CAPs Required | # of CAPs Closed | 2018 Final Follow-Up Review Score |
|---|---|---|---|---|---|
| I | Provider Selection | 100% | 0 | NA | **100%** |
| II | Subcontracts and Delegation | 100% | 0 | NA | **100%** |
| III | Credentialing | 94% | 5 | 5 | **100%** |
| IV | Quality Assessment and Performance Improvement | 94% | 1 | 1 | **100%** |
| V | Health Information System | 100% | 0 | NA | **100%** |
| VI | Practice Guidelines | 100% | 0 | NA | **100%** |
| | **Totals** | **96%** | **6** | **6** | **100%** |

***NA*:** Not Applicable. Reevaluation was not necessary as the health plan achieved 100% for the standard.

### Strengths

'Ohana CCS completed all six CAP items during 2018. To address the *Credentialing* standard deficiencies, 'Ohana CCS developed a cover letter to notify credentialing applicants of their rights and updated the organizational provider policies and procedures to include the acceptable threshold for on-site quality assessments conducted by CMS or an approved survey agency. 'Ohana CCS also revised the credentialing policies and procedures to ensure complete Disclosure of Ownership forms were obtained at the time of recredentialing. To address the *Quality Assessment and Performance Improvement* deficiency, 'Ohana CCS hired a registered nurse, licensed in the State of Hawaii, to fill the quality assurance/utilization review coordinator position as required by the behavioral health organization's contract with the State.

### Areas for Improvement

As a result of its CAP interventions, ‘Ohana CCS was found to be fully compliant with the *Credentialing* and *Quality Assessment and Performance Improvement* standards and had no continuing corrective actions.

## *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. ‘Ohana CCS was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that ‘Ohana CCS 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. ‘Ohana CCS elected to use nine standard and three nonstandard supplemental data sources for its performance measure reporting. ‘Ohana CCS used EMMA, a case management system, to capture data for the state-defined behavioral health assessment (BHA) measure. The BHA measure calculation data were manually tracked on a spreadsheet, and completed BHAs were loaded to EMMA. About 12 agencies were contracted to complete the BHAs and submit them to ‘Ohana CCS. No concerns were identified, and these data sources were approved for HEDIS 2018 measure reporting.

Based on ‘Ohana CCS’ data systems and processes, the auditors made one recommendation:

- HSAG recommended that ‘Ohana CCS ensures appropriate Roadmap documentation for supplemental data going forward.

‘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 Xcelys enrollment system.

All HEDIS measures reported by ‘Ohana CCS were administrative measures and did not require MRRV.

### Access to Care Performance Measure Results

‘Ohana CCS’ Access to Care performance measure results are shown in Table 3-57. Due to technical specification changes in 2018, it is inappropriate to compare the *Initiation and Engagement of AOD Abuse or Dependence Treatment* rates to national Medicaid benchmarks or to analyze the relative difference from HEDIS 2017 to 2018.

**Table 3-57—'Ohana CCS' HEDIS Results for QI Measures Under Access to Care**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment***[1] | | | | |
| *Initiation of AOD Treatment—Total—Total* | — | 42.60% | — | NC |
| *Engagement of AOD Treatment—Total—Total* | — | 15.62% | — | NC |

[1] *Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*

## Behavioral Health Performance Measure Results

'Ohana CCS' Behavioral Health performance measure results are shown in Table 3-58. One measure rate within this domain (*Behavioral Health Assessment—BHA Completion Within 30 Days of Enrollment [Within Standard]*) reported a relative improvement of more than 10 percent in 2018. Both *Follow-Up After Emergency Department Visit for Mental Illness* measure rates ranked at or above the national Medicaid 75th percentile, with the *30-Day Follow-Up* indicator ranking at or above the 90th percentile. Additionally, five measure rates ranked at or above the national Medicaid 50th percentile but below the 75th percentile. Conversely, the remaining two measure rates compared to benchmarks ranked below the national Medicaid 25th percentile. The measure in this domain with an MQD Quality Strategy target for HEDIS 2018 (*Follow-Up After Hospitalization for Mental Illness*) was not appropriate to compare to the established target, the 75th percentile, due to technical specification changes.

**Table 3-58—'Ohana CCS' HEDIS Results for QI Measures Under Behavioral Health**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Adherence to Antipsychotic Medications for Individuals With Schizophrenia*** | | | | |
| *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* | 66.53% | 65.92% | -0.92% | ★★★ |
| ***Antidepressant Medication Management***[1] | | | | |
| *Effective Acute Phase Treatment* | 41.00% | 44.01% | 7.34% | ★ |
| *Effective Continuation Phase Treatment* | 30.09% | 32.39% | 7.64% | ★ |
| ***Behavioral Health Assessment*** | | | | |
| *BHA Completion Within 30 Days of Enrollment (Within Standard)* | 29.86% | 45.40% | 52.04% | NC |
| *BHA Completion within 31-60 Days of Enrollment (Not Within Standard)* | 21.30% | 22.85% | 7.28% | NC |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Follow-Up After Emergency Department Visit for AOD Abuse or Dependence[1]*** | | | | |
| *7-Day Follow-Up—13-17 Years* | NA | NA | — | NA |
| *7-Day Follow-Up—18+ Years* | 14.24% | 13.98% | -1.83% | ★★★ |
| *7-Day Follow-Up—Total* | 14.24% | 13.98% | -1.83% | ★★★ |
| *30-Day Follow-Up—13-17 Years* | NA | NA | — | NA |
| *30-Day Follow-Up—18+ Years* | 21.52% | 20.81% | -3.30% | ★★★ |
| *30-Day Follow-Up—Total* | 21.52% | 20.81% | -3.30% | ★★★ |
| ***Follow-Up After Emergency Department Visit for Mental Illness[1]*** | | | | |
| *7-Day Follow-Up* | 54.34% | 56.70% | 4.34% | ★★★★ |
| *30-Day Follow-Up* | 71.70% | 78.35% | 9.27% | ★★★★★ |
| ***Follow-Up After Hospitalization for Mental Illness[2]*** | | | | |
| *7-Day Follow-Up* | — | 74.19% | — | NC |
| *30-Day Follow-Up* | — | 90.32% | — | NC |

*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Utilization and Health Plan Descriptive Information Performance Measure Results

'Ohana CCS' Utilization and Health Plan Descriptive Information performance measure results are shown in Table 3-59. With the exception of *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*, measure rates in this domain are presented for information only, as lower or higher rates are not indicative of performance. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2018.

**Table 3-59—Ohana CCS' HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information**

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| ***Ambulatory Care—Total (per 1,000 Member Months)*** | | | | |
| *ED Visits—Total** | 113.04 | 128.37 | 13.56% | ★ |

| Measure | HEDIS 2017 Rate | HEDIS 2018 Rate | Relative Difference | 2018 Performance Level |
|---|---|---|---|---|
| *Outpatient Visits—Total* | 796.99 | 728.99 | -8.53% | NC |
| ***Enrollment by Product Line—Total*** | | | | |
| *0–19 Years Subtotal Percentage—Total* | 0.32% | 0.28% | -12.50% | NC |
| *20–44 Years Subtotal Percentage—Total* | 31.16% | 30.36% | -2.57% | NC |
| *45–64 Years Subtotal Percentage—Total* | 58.34% | 57.94% | -0.69% | NC |
| *65+ Years Subtotal Percentage—Total* | 10.18% | 11.42% | 12.18% | NC |
| ***Mental Health Utilization*** | | | | |
| *Any Service—Total*[1] | 93.80% | 109.14% | 16.35% | NC |
| *Inpatient—Total* | 8.38% | 1.20% | -85.68% | NC |
| *Intensive Outpatient or Partial Hospitalization—Total*[1] | 2.56% | 1.04% | -59.38% | NC |
| *Outpatient—Total*[2] | — | 106.89% | — | NC |
| *ED—Total*[2] | — | 0.59% | — | NC |
| *Telehealth—Total*[2] | — | 0.63% | — | NC |

** For this indicator, a lower rate indicates better performance.*
*[1] Due to changes in the technical specifications for this measure for HEDIS 2018, exercise caution when trending HEDIS 2018 rates to prior years.*
*[2] Due to changes in the technical specifications for this measure in HEDIS 2018, NCQA does not recommend trending between 2018 and prior years; therefore, prior year rates are not displayed and comparisons to benchmarks are not performed for this measure.*
*NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*— Indicates that the measure rate is not displayed in this report or that the relative difference could not be calculated because one of the rates was not reportable.*
*2018 performance levels represent the following percentile comparisons:*
★★★★★ *= At or above the 90th percentile*
★★★★ *= Between the 75th to 89th percentiles*
★★★ *= Between the 50th to 74th percentiles*
★★ *= Between the 25th to 49th percentiles*
★ *= Below the 25th percentile*

## Conclusions and Recommendations

Based on HSAG's analyses of those 'Ohana CCS measure rates with comparable benchmarks, two of the measure rates (20.0 percent) ranked at or above the national Medicaid 75th percentile in 2018. An additional five measure rates (50.0 percent) ranked at or above the national Medicaid 50th percentile but below the 75th percentile, indicating moderate performance related to the Behavioral Health domain. Three measure rates (30.0 percent) ranked below the national Medicaid 25th percentile, suggesting opportunities for improvement. HSAG recommends that 'Ohana CCS 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—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*

- Utilization and Health Plan Descriptive Information
  - *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*

## Validation of Performance Improvement Projects

For validation year 2018, 'Ohana CCS submitted two state-mandated PIPs for validation—*Improving Behavioral Health Assessment (BHA) Completion Rates* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge***.** These rapid-cycle PIPs were implemented in June 2017. The PIP topics represent key areas of focus for improvement and are part of the MQD Quality Strategy.

The *Improving Behavioral Health Assessment Completion Rates* PIP addressed CMS' requirements related to quality outcomes—specifically, timeliness of care and services. The focus of the PIP was to improve the completion of behavioral health assessments within 30 days of enrollment. The targeted population consisted of new members assigned to one of the following Community-Based Case Management (CBCM) agencies: Community Empowerment Resources, Institute of Human Services, Mental Health Kokua (Oahu and Kauai), North Shore Mental Health, or Aloha House.

The *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP addressed CMS' requirements related to quality outcomes—specifically, access to and timeliness of care and services. The focus of the PIP was to increase the percentage of members who were discharged from an inpatient psychiatric facility who had a follow-up visit with a mental health provider within seven days of discharge. The targeted population consisted of members assigned to one of the following CBCM agencies: Community Empowerment Resources, Helping Hands Hawaii, North Shore Mental Health, or State of Hawaii Department of Health—Adult Mental Health Division.

Table 3-60 outlines 'Ohana CCS' SMART Aim for each PIP.

**Table 3-60—PIP Topic and SMART Aim Statements for 'Ohana CCS**

| PIP Topic | SMART Aim Statement |
|---|---|
| *Improving Behavioral Health Assessment Completion Rates* | By December 31, 2018, improve BHA compliance rates of newly enrolled CCS members assigned in four CBCM agencies (Community Empowerment Resources, Institute of Human Services, North Shore Mental Health, Aloha House, Mental Health Kokua on Oahu and Kauai) from 16% to 50%. |
| *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* | By December 31, 2018, increase mental health 7-day follow-up compliance rates of CCS members in four CBCM agencies (Community Empowerment Resources, Helping Hands Hawaii, North Shore Mental Health, and State of Hawaii Department of Health—Adult Mental Health Division) from 53% to 61%. |

## Findings

'Ohana CCS successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2018 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2019 annual validation.

## Interventions

'Ohana CCS is testing interventions using PDSA methodology through the SMART Aim end date of December 31, 2018. 'Ohana CCS' intervention for the *Improving Behavioral Health Assessment Completion Rates* PIP involves a follow-up email notification from the health plan to the agencies, notifying them of newly assigned members.

'Ohana CCS provided an update on intervention testing (Module 4) in June 2018 and October 2018. For the October 2018 update, HSAG provided feedback that it appeared the intervention had success in March, April, May, and June 2018; however, for July and August 2018, the results were zero and one.

For the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP, 'Ohana CCS' intervention entails enlisting CBCM agency staff to visit members while admitted into inpatient care or arrange for community outreach after discharge that would ensure members are following the discharge plan and have appropriate services, such as transportation. For the October 2018 update, HSAG provided feedback that it appeared the intervention was effective based on the evaluation results.

## Strengths and Weaknesses

'Ohana CCS was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Improving Behavioral Health Assessment Completion Rates* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* rapid-cycle PIPs.

## Recommendations for Improvement

Based on the 2018 PIP validation, HSAG recommended the following:

- 'Ohana CCS should define all intervention effectiveness measures appropriately to measure the impact of interventions.
- 'Ohana CCS should clearly report all data results in Modules 4 and 5.
- The health plan should address all Module 4 pre-validation review and progress update feedback in the final submission of Module 4.
- 'Ohana CCS should clearly link improvement in the SMART Aim to intervention(s) tested for the PIP. The health plan should report numerators, denominators, and percentage results at least monthly for the SMART Aim measure and intervention effectiveness measure(s).

- 'Ohana CCS should work on completing the Module 5 submission form as the PIP progresses.
- 'Ohana CCS should test an intervention until the SMART Aim end date, December 31, 2018.
- If the health plan needs to abandon an intervention, it should contact HSAG as soon as possible to discuss next steps.
- 'Ohana CCS should use the PIP Reference Guide and contact HSAG as often as needed for technical assistance.

## *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 illustrated 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 was mixed and highlighted some room for improvement.

Since 'Ohana CCS performed moderately well during the 2017 compliance review, only six corrective action items needed to be addressed in 2018. Encompassing the *Credentialing* and *Quality Assessment and Performance Improvement* standards, 'Ohana CCS took the necessary steps to ensure its policies and procedures were updated to ensure providers are advised of their rights, identify an acceptable threshold for on-site assessments, and acquisition of Disclosure of Ownership forms. 'Ohana CCS also hired appropriate staff to oversee its QAPI program. As a result, 'Ohana CCS continued to show that it had systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes.

Overall, three (30 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. Two measure rates in the Behavioral Health domain (i.e., *Follow-Up After Emergency Department Visit for Mental Illness* [two rates]) were at or above the 75th percentile, with the *30-day Follow-Up* indicator at or above the 90th percentile.

Finally, although final results for 'Ohana CCS' PIPs were not available in 2018, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Improving Behavioral Health Assessment Completion Rates* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* rapid-cycle PIPs.

# 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 provides information that can be used to compare all five Hawaii Medicaid managed care health plans' performance on implementing corrective action plans (CAPs) required to resolve deficiencies for each of the six compliance standard areas reviewed the prior year.

**Table 4-1—Total CAPs and Resolved CAPs by Health Plan and by Standard**

| Standard Name | AlohaCare QI | HMSA QI | KHFP QI | 'Ohana QI | UHC CP QI | 'Ohana CCS | Total # CAPs per Standard |
|---|---|---|---|---|---|---|---|
| I. Provider Selection | NA | NA | NA | NA | NA | NA | **NA** |
| II. Subcontracts and Delegation | 1/1 | NA | 2/7 | NA | NA | NA | **3/8** |
| III. Credentialing | 2/2 | 4/4 | 2/7 | 6/6 | 7/7 | 5/5 | **26/31** |
| IV. Quality Assessment and Performance Improvement | NA | NA | NA | NA | NA | 1/1 | **1/1** |
| V. Health Information Systems | NA | NA | NA | NA | NA | NA | **NA** |
| VI. Practice Guidelines | NA | NA | NA | NA | NA | NA | **NA** |
| **Total # CAPs and Resolved CAPs by Health Plan:** | **3/3** | **4/4** | **4/14** | **6/6** | **7/7** | **6/6** | **30/40** |

*Numerator = # of CAPs "closed" and found compliant during follow-up review.*
*Denominator = Total # CAPs required for the standard following prior year (2017) compliance review.*
*NA = Not Applicable. Reevaluation was not necessary as the health plan achieved 100 percent for the standard.*

Across all six health plans, performance was strongest in the areas of *Provider Selection*, *Health Information Systems* and *Practice Guidelines* during the previous year's review, with no CAPs requiring follow-up this year. *Quality Assessment and Performance Improvement* was also a strong performance area, with only one health plan requiring corrective action.

The *Credentialing* standard had the highest number of individual elements requiring CAPs (31) followed by the *Subcontracts and Delegation* standard with eight elements requiring CAPs. KFHP QI had the highest number of individual elements requiring correction. HMSA QI, 'Ohana QI, and UHC CP QI had the fewest number of standard areas requiring CAPs (1), while AlohaCare had the fewest number of individual elements requiring CAPs (3).

AlohaCare QI, HMSA QI, ‘Ohana QI and CCS, and UHC CP QI successfully resolved all CAP areas during the reevaluation period. KFHP QI has 10 continuing CAP items to complete in early 2019.

# 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 2018 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 4.0 = *Partially Compliant*) and HMSA QI (IS 4.0 = *Partially Compliant*). Overall, the health plans followed the NCQA HEDIS 2018 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of *Reportable* except for one measure indicator for AlohaCare that received a *Biased Rate* designation *(Comprehensive Diabetes Care HbA1c Control [<7.0%])* and one measure from HMSA that received a *Biased Rate* designation (*Comprehensive Diabetes Care HbA1c Control [<7.0%]).*

**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 7.0 Data Integration |
|---|---|---|---|---|---|---|
| **AlohaCare QI** | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Partially Compliant* | *Fully Compliant* | *Fully Compliant* |
| **HMSA QI** | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Partially Compliant* | *Fully Compliant* | *Fully Compliant* |
| **KFHP QI** | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* |
| **‘Ohana QI** | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* |
| **UHC CP QI** | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *Fully Compliant* | *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’ 2018 measure rates and their performance relative to the NCQA

national Medicaid HEDIS 2017 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

## 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 2018 Access to Care Measure Rates**

| Measure | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI |
|---|---|---|---|---|---|
| ***Adults' Access to Preventive/Ambulatory Health Services*** | | | | | |
| *20–44 Years* | 60.30% ★ | 70.26% ★ | 74.14% ★★ | 59.33% ★ | 57.68% ★ |
| *45–64 Years* | 72.80% ★ | 81.40% ★ | 83.64% ★★ | 78.70% ★ | 79.40% ★ |
| *65 Years and Older* | 79.98% ★ | 86.42% ★★ | 94.92% ★★★★★ | 89.32% ★★★ | 94.77% ★★★★★ |
| *Total* | 65.66% ★ | 74.78% ★ | 78.70% ★★ | 72.57% ★ | 76.83% ★★ |
| ***Children and Adolescents' Access to Primary Care Practitioners*** | | | | | |
| *12–24 Months* | 95.88% ★★★ | 96.43% ★★★ | 99.23% ★★★★★ | 91.27% ★ | 93.61% ★★ |
| *25 Months–6 Years* | 83.78% ★ | 89.27% ★★★ | 92.97% ★★★★ | 77.87% ★ | 78.90% ★ |
| *7–11 Years* | 85.81% ★ | 91.61% ★★★ | 92.26% ★★★ | 80.78% ★ | 80.89% ★ |
| *12–19 Years* | 83.74% ★ | 89.52% ★★★ | 90.99% ★★★ | 77.05% ★ | 79.08% ★ |
| ***Initiation and Engagement of AOD Abuse or Dependence Treatment*** | | | | | |
| *Initiation of AOD Treatment—Total—Total* | 38.77% — | 36.97% — | 41.95% — | 48.42% — | 38.62% — |
| *Engagement of AOD Treatment—Total—Total* | 10.54% — | 15.36% — | 13.83% — | 15.04% — | 11.38% — |

*— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*

[4-1] 2018 performance measure rates were compared to HEDIS Audit Means and Percentiles for HEDIS 2017 for benchmarking.

Within the Access to Care performance measure domain, KFHP QI performed best among the health plans, with three measure rates ranking at or above the national Medicaid 75th percentile, of which two were at or above the 90th percentile. AlohaCare QI and 'Ohana QI demonstrated the worst performance among the health plans, with all but one measure rate ranking below the national Medicaid 25th percentile. Health plans demonstrated the worst performance for the *Adults' Access to Preventive/Ambulatory Health Services* measure, with no plan meeting the national Medicaid 50th percentile for three of the four measure indicators.

There were no measures in this domain with MQD Quality Strategy targets for 2018.

## 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 2018 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* | 49.64% ★★ | 48.18% ★★ | 43.31% ★★ | 39.17% ★ | 45.74% ★★ |
| ***Childhood Immunization Status*** | | | | | |
| *Combination 3* | 59.61% ★ | 75.91% ★★★★ | 80.24% ★★★★★ | 55.12% ★ | 60.22% ★ |
| *DTaP* | 64.72% ★ | 81.02% ★★★ | 83.85% ★★★★ | 61.75% ★ | 67.51% ★ |
| *Hepatitis B* | 80.54% ★ | 86.62% ★★ | 92.39% ★★★ | 71.08% ★ | 82.07% ★ |
| *HiB* | 78.83% ★ | 89.78% ★★★ | 90.79% ★★★ | 73.80% ★ | 83.47% ★ |
| *IPV* | 80.29% ★ | 87.83% ★★ | 92.26% ★★★ | 71.39% ★ | 80.95% ★ |
| *MMR* | 80.54% ★ | 90.02% ★★ | 91.59% ★★★ | 76.51% ★ | 78.99% ★ |
| *Pneumococcal Conjugate* | 64.23% ★ | 80.29% ★★★ | 81.71% ★★★ | 62.05% ★ | 67.23% ★ |
| *VZV* | 78.83% ★ | 88.81% ★★ | 90.92% ★★★ | 75.90% ★ | 78.71% ★ |
| ***Immunizations for Adolescents*** | | | | | |
| *Combination 1 (Meningococcal, Tdap)* | 51.82% ★ | 59.85% ★ | 82.15% ★★★ | 34.83% ★ | 49.15% ★ |
| *Combination 2 (Meningococcal, Tdap, HPV)* | 22.38% — | 25.06% — | 42.96% — | 11.61% — | 20.09% — |
| *HPV* | 24.33% — | 27.74% — | 44.77% — | 14.98% — | 23.50% — |

| Measure | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI |
|---|---|---|---|---|---|
| *Meningococcal* | 55.47% ★ | 63.02% ★ | 84.94% ★★★ | 40.82% ★ | 54.27% ★ |
| *Tdap* | 56.69% ★ | 66.91% ★ | 83.82% ★★ | 38.95% ★ | 54.70% ★ |
| ***Well-Child Visits in the First 15 Months of Life*** | | | | | |
| *No Well-Child Visits** | 0.97% ★★★★ | 0.93% ★★★★ | 0.57% ★★★★ | 1.90% ★★ | 3.50% ★ |
| *Six or More Well-Child Visits* | 72.75% ★★★★★ | 70.09% ★★★★ | 78.97% ★★★★★ | 65.08% ★★★ | 70.70% ★★★★ |
| ***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* | 66.42% ★★ | 78.66% ★★★★ | 82.36% ★★★★ | 65.51% ★ | 61.12% ★ |
| ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** | | | | | |
| *BMI Percentile—Total* | 84.43% ★★★★ | 83.94% ★★★★ | 93.40% ★★★★★ | 72.93% ★★★ | 83.29% ★★★★ |
| *Counseling for Nutrition—Total* | 73.48% ★★★ | 73.72% ★★★ | 100.00% ★★★★★ | 62.93% ★★ | 69.83% ★★★ |
| *Counseling for Physical Activity—Total* | 71.05% ★★★★ | 57.66% ★★ | 100.00% ★★★★★ | 50.73% ★★ | 62.59% ★★★ |

*— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
** For this indicator, a lower rate indicates better performance.*
*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*

Within the Children's Preventive Health performance measure domain, KFHP QI performed best among the health plans, with eight measure rates ranking at or above the national Medicaid 75th percentile, of which five were at or above the 90th percentile. 'Ohana QI demonstrated the worst performance among the health plans, with all but two measure rates (*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*) ranking below the national Medicaid 50th percentile, and 13 measure rates ranking below the 25th percentile. Health plans demonstrated the worst performance for *Adolescent Well-Care Visits*, with all health plans ranking below the national Medicaid 50th percentile, while performance was best for *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, as all health plans performed above the national Medicaid 50th percentile for both of these measures.

Only one measure (*Childhood Immunization Status—Combination 3*) within the Children's Preventive Health domain was associated with an MQD Quality Strategy target in 2018. Of the health plans, only HMSA QI and 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 2018 Women's Health Measure Rates**

| Measure | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI |
|---|---|---|---|---|---|
| ***Breast Cancer Screening*** | | | | | |
| *Breast Cancer Screening* | 47.48%<br>— | 62.07%<br>— | 75.34%<br>— | 52.07%<br>— | 62.06%<br>— |
| ***Cervical Cancer Screening*** | | | | | |
| *Cervical Cancer Screening* | 48.42%<br>★ | 65.00%<br>★★★ | 79.39%<br>★★★★★ | 51.82%<br>★★ | 47.45%<br>★ |
| ***Chlamydia Screening in Women*** | | | | | |
| *16–20 Years* | 37.01%<br>★ | 51.74%<br>★★ | 78.26%<br>★★★★★ | 39.13%<br>★ | 47.93%<br>★★ |
| *21–24 Years* | 41.00%<br>★ | 56.10%<br>★ | 80.63%<br>★★★★★ | 54.62%<br>★ | 59.56%<br>★★ |
| *Total* | 38.94%<br>★ | 53.77%<br>★★ | 79.21%<br>★★★★★ | 49.25%<br>★ | 55.85%<br>★★ |
| ***Prenatal and Postpartum Care*** | | | | | |
| *Timeliness of Prenatal Care* | 64.23%<br>★ | 71.29%<br>★ | 90.00%<br>★★★★ | 71.53%<br>★ | 73.11%<br>★ |
| *Postpartum Care* | 51.82%<br>★ | 49.15%<br>★ | 80.46%<br>★★★★★ | 46.72%<br>★ | 52.32%<br>★ |

*— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*
*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*

Within the Women's Health performance measure domain, KFHP QI performed best among the health plans, as all six measure rates ranked at or above the national Medicaid 75th percentile, of which five were at or above the 90th percentile. AlohaCare QI demonstrated the worst performance among the health plans, with all measure rates ranking below the national Medicaid 25th percentile. Additionally, 'Ohana QI and UHC CP QI also showed low performance, with all measure rates ranking below the national Medicaid 50th percentile. The *Prenatal and Postpartum Care* measure rates scored consistently low across all health plans except for KFHP QI.

There were two measures[4-2] within the Women's Health domain associated with an MQD Quality Strategy target in 2018. Of the health plans, only KFHP QI met or exceeded the target for *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*.

[4-2] The MQD Quality Strategy targets were established for three measures within the Women's Health domain: *Breast Cancer Screening*, *Cervical Cancer Screening*, and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*. Due to technical specification changes in 2018, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Breast Cancer Screening* measure.

## 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 2018 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*** | | | | | |
| *ACE Inhibitors or ARBs* | 86.44% ★★ | 83.76% ★ | 91.37% ★★★★ | 91.63% ★★★★ | 92.93% ★★★★★ |
| *Diuretics* | 87.26% ★★ | 83.44% ★ | 90.09% ★★★ | 92.15% ★★★★ | 93.81% ★★★★★ |
| *Total* | 86.70% — | 83.66% — | 90.96% — | 91.80% — | 93.20% — |
| ***Comprehensive Diabetes Care*** | | | | | |
| *HbA1c Testing* | 79.32% ★ | 84.33% ★★ | 92.91% ★★★★★ | 85.90% ★★ | 88.24% ★★★ |
| *HbA1c Poor Control (>9.0%)** | 49.39% ★ | 40.85% ★★★ | 30.39% ★★★★ | 46.44% ★★ | 33.86% ★★★★ |
| *HbA1c Control (<7.0%)* | BR | BR | 32.74% ★★ | 27.17% ★ | 35.67% ★★ |
| *HbA1c Control (<8.0%)* | 40.15% ★ | 48.94% ★★★ | 57.99% ★★★★ | 44.04% ★★ | 54.93% ★★★★ |
| *Eye Exam (Retinal) Performed* | 54.50% ★★ | 62.85% ★★★ | 68.43% ★★★★★ | 64.24% ★★★★ | 67.41% ★★★★ |
| *Medical Attention for Nephropathy* | 87.35% ★ | 88.20% ★ | 94.42% ★★★★★ | 89.68% ★★ | 92.85% ★★★★ |
| *Blood Pressure Control (<140/90 mm Hg)* | 55.23% ★★ | 59.15% ★★ | 77.55% ★★★★★ | 59.23% ★★ | 68.04% ★★★ |
| ***Controlling High Blood Pressure*** | | | | | |
| *Controlling High Blood Pressure* | 47.69% ★★ | 40.63% ★ | 81.42% ★★★★★ | 54.55% ★★ | 63.78% ★★★ |
| ***Medication Management for People With Asthma*** | | | | | |
| *Medication Compliance 50%—Total* | 63.77% ★★★ | 58.74% ★★★ | 48.89% ★ | 69.91% ★★★★ | 62.89% ★★★ |
| *Medication Compliance 75%—Total* | 42.51% ★★★★ | 36.49% ★★★ | 28.08% ★★ | 46.46% ★★★★ | 45.88% ★★★★ |

*— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*

** For this indicator, a lower rate indicates better performance.*

*BR indicates that the rate was materially biased.*

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*

Within the Care for Chronic Conditions performance measure domain, KFHP QI performed best among the health plans, with eight measure rates ranking at or above the national Medicaid 75th percentile, of which five were at or above the 90th percentile. UHC CP QI's performance was similar, with seven

measure rates ranking at or above the national Medicaid 75th percentile, of which two measure rates were at or above the 90th percentile. AlohaCare QI demonstrated the worst performance among the health plans, with nine measure rates ranking below the national Medicaid 50th percentile. 'Ohana QI and HMSA QI also showed low performance, with seven and six measure rates, respectively, ranking below the national Medicaid 50th percentile.

Eight measures[4-3] within the Care of Chronic Conditions domain were associated with an MQD Quality Strategy target in 2018. Of the health plans, KFHP QI met or exceeded six targets; UHC CP QI met or exceeded four targets; 'Ohana QI met or exceeded three targets; HMSA QI met or exceeded two targets; and AlohaCare QI met or exceeded one target.

## 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 2018 Behavioral Health Measure Rates**

| Measure | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI |
|---|---|---|---|---|---|
| ***Antidepressant Medication Management*** | | | | | |
| *Effective Acute Phase Treatment* | 55.16% ★★★ | 47.67% ★ | 48.50% ★★ | 51.26% ★★ | 52.37% ★★★ |
| *Effective Continuation Phase Treatment* | 37.67% ★★★ | 32.08% ★ | 34.96% ★★ | 34.71% ★★ | 37.26% ★★★ |
| ***Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*** | | | | | |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia* | NA | NA | NA | 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* | 71.46% ★ | 68.45% ★ | 85.00% ★★★★ | 71.14% ★ | 75.68% ★ |
| ***Follow-Up After Emergency Department Visit for AOD Abuse or Dependence*** | | | | | |
| *7-Day Follow-Up—13–17 Years* | 10.53% ★★★ | 12.90% ★★★★ | NA | NA | NA |
| *7-Day Follow-Up—18+ Years* | 15.92% ★★★ | 16.38% ★★★ | 19.74% ★★★★ | 10.86% ★★★ | 8.53% ★★ |
| *7-Day Follow-Up—Total* | 15.58% ★★★ | 16.14% ★★★ | 18.28% ★★★★ | 10.68% ★★ | 8.64% ★★ |

[4-3] Within this domain, there were 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 |
|---|---|---|---|---|---|
| *30-Day Follow-Up—13–17 Years* | 10.53% ★★★ | 14.52% ★★★ | NA | NA | NA |
| *30-Day Follow-Up—18+ Years* | 23.26% ★★★ | 24.88% ★★★ | 28.95% ★★★★ | 17.74% ★★★ | 16.63% ★★★ |
| *30-Day Follow-Up—Total* | 22.45% ★★★ | 24.15% ★★★ | 25.81% ★★★ | 17.43% ★★★ | 16.63% ★★★ |
| ***Follow-Up After Emergency Department Visit for Mental Illness*** | | | | | |
| *7-Day Follow-Up* | 26.02% ★ | 26.97% ★ | 34.00% ★★ | 28.90% ★ | 32.41% ★★ |
| *30-Day Follow-Up* | 43.21% ★ | 44.79% ★ | 52.00% ★★ | 45.89% ★★ | 52.24% ★★ |
| ***Follow-Up After Hospitalization for Mental Illness*** | | | | | |
| *7-Day Follow-Up* | 20.83% — | 36.94% — | 55.00% — | 38.60% — | 50.62% — |
| *30-Day Follow-Up* | 36.74% — | 55.99% — | 74.29% — | 57.21% — | 61.73% — |
| ***Follow-Up Care for Children Prescribed ADHD Medication*** | | | | | |
| *Initiation Phase* | 36.90% ★ | 51.96% ★★★★ | 66.67% ★★★★★ | NA | NA |
| *Continuation and Maintenance Phase* | NA | 57.97% ★★★ | NA | NA | NA |

*NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.*
*— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*

Within the Behavioral Health domain, KFHP QI performed best among the health plans, with five measure rates ranking at or above the national Medicaid 75th percentile, of which one was at or above the 90th percentile. 'Ohana QI and UHC CP QI demonstrated the worst performance among the health plans, with more than half of their reportable measure rates ranking below the national Medicaid 50th percentile. The health plans performed best for *Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—30-Day Follow-Up*, as all health plans ranked at or above the national Medicaid 50th percentile for all three indicators. Health plans demonstrated the worst performance for *Follow-Up After Emergency Department Visit for Mental Illness*, as all health plans ranked below the national Medicaid 50th percentile for both indicators.

Due to changes in technical specifications in 2018, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Follow-Up After Hospitalization for Mental Illness* measure.

## 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 2018 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** | 49.15 ★★★★ | 42.11 ★★★★★ | 31.51 ★★★★★ | 62.71 ★★ | 51.89 ★★★★ |
| *Outpatient Visits—Total* | 280.91 — | 327.07 — | 264.18 — | 570.59 — | 460.05 — |
| ***Enrollment by Product Line—Total*** | | | | | |
| *0–19 Years Subtotal Percentage—Total* | 48.88% — | 51.67% — | 56.63% — | 23.91% — | 20.37% — |
| *20–44 Years Subtotal Percentage—Total* | 31.57% — | 29.87% — | 25.82% — | 34.22% — | 31.47% — |
| *45–64 Years Subtotal Percentage—Total* | 16.01% — | 16.68% — | 15.35% — | 27.92% — | 24.81% — |
| *65+ Years Subtotal Percentage—Total* | 3.55% — | 1.78% — | 2.20% — | 13.95% — | 23.35% — |
| ***Inpatient Utilization—General Hospital/Acute Care—Total*** | | | | | |
| *Maternity—Average Length of Stay—Total* | 2.58 — | 2.52 — | 2.57 — | 2.70 — | 2.89 — |
| *Maternity—Days per 1,000 Member Months—Total* | 6.99 — | 6.07 — | 5.27 — | 5.37 — | 5.82 — |
| *Maternity—Discharges per 1,000 Member Months—Total* | 2.72 — | 2.41 — | 2.05 — | 1.99 — | 2.01 — |
| *Medicine—Average Length of Stay—Total* | 5.33 — | 4.71 — | 4.80 — | 6.61 — | 5.79 — |
| *Medicine—Days per 1,000 Member Months—Total* | 15.89 — | 10.27 — | 9.73 — | 53.75 — | 38.25 — |
| *Medicine—Discharges per 1,000 Member Months—Total* | 2.98 — | 2.18 — | 2.03 — | 8.13 — | 6.61 — |
| *Surgery—Average Length of Stay—Total* | 9.83 — | 7.75 — | 6.71 — | 9.93 — | 10.23 — |
| *Surgery—Days per 1,000 Member Months—Total* | 14.39 — | 7.25 — | 5.28 — | 33.75 — | 32.45 — |
| *Surgery—Discharges per 1,000 Member Months—Total* | 1.46 — | 0.94 — | 0.79 — | 3.40 — | 3.17 — |
| *Total Inpatient—Average Length of Stay—Total* | 5.54 — | 4.54 — | 4.43 — | 7.05 — | 6.72 — |
| *Total Inpatient—Days per 1,000 Member Months—Total* | 35.21 — | 21.75 — | 18.55 — | 91.41 — | 74.48 — |
| *Total Inpatient—Discharges per 1,000 Member Months—Total* | 6.36 — | 4.79 — | 4.19 — | 12.97 — | 11.09 — |

| Measure | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI |
|---|---|---|---|---|---|
| ***Mental Health Utilization*** | | | | | |
| *Any Service—Total* | 8.29%<br>— | 10.80%<br>— | 7.10%<br>— | 14.07%<br>— | 11.49%<br>— |
| *Inpatient—Total* | 0.31%<br>— | 0.21%<br>— | 0.24%<br>— | 0.60%<br>— | 0.55%<br>— |
| *Intensive Outpatient or Partial Hospitalization—Total* | 0.08%<br>— | 0.03%<br>— | 0.05%<br>— | 0.02%<br>— | 0.17%<br>— |
| *Outpatient—Total* | 7.93%<br>— | 10.55%<br>— | 6.88%<br>— | 13.09%<br>— | 10.84%<br>— |
| *ED—Total* | 0.10%<br>— | 0.03%<br>— | 0.06%<br>— | 0.37%<br>— | 0.08%<br>— |
| *Telehealth—Total* | 0.02%<br>— | 0.03%<br>— | 0.03%<br>— | 0.04%<br>— | 0.02%<br>— |
| ***Plan All-Cause Readmissions*** | | | | | |
| *Index Total Stays—Observed Readmissions—Ages 18-44** | 14.58%<br>— | 10.05%<br>— | 12.27%<br>— | 18.03%<br>— | 12.25%<br>— |
| *Index Total Stays—Observed Readmissions—Ages 45-54** | 9.77%<br>— | 10.87%<br>— | 12.93%<br>— | 18.50%<br>— | 17.44%<br>— |
| *Index Total Stays—Observed Readmissions—Ages 55-64** | 11.28%<br>— | 12.19%<br>— | 13.40%<br>— | 17.05%<br>— | 17.62%<br>— |
| *Index Total Stays—Observed Readmissions—Total** | 12.36%<br>— | 10.90%<br>— | 12.80%<br>— | 17.73%<br>— | 16.08%<br>— |

*— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.*

** For this indicator, a lower rate indicates better performance.*

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*

Within the Utilization and Health Plan Descriptive Information performance measure domain, four of five health plans ranked at or above the national Medicaid 75th percentile for *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*. 'Ohana QI was the only health plan that ranked below the national Medicaid 50th percentile. HMSA QI and KFHP QI met the 2018 MQD Quality Strategy for the *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure.

For the *Plan All-Cause Readmissions* measure, performance could not be compared to benchmarks because national benchmarks are not available for the Medicaid product line. The remaining reported measure rates for the Utilization and Health Plan Descriptive Information domain are presented for information only. 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 | ʻOhana QI | UHC CP QI |
|---|---|---|---|---|---|
| **Children's Preventive Health** | | | | | |
| *Childhood Immunization Status—Combination 3* (75th Percentile) | Not Met | Met | Met | Not Met | Not Met |
| **Women's Health** | | | | | |
| *Breast Cancer Screening* (75th Percentile) | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| *Cervical Cancer Screening* (75th Percentile) | Not Met | Not Met | Met | Not Met | Not Met |
| *Prenatal and Postpartum Care—Timeliness of Prenatal Care* (75th Percentile) | Not Met | Not Met | Met | Not Met | Not Met |
| **Care for Chronic Conditions** | | | | | |
| *Comprehensive Diabetes Care—HbA1c Testing* (75th Percentile) | Not Met | Not Met | Met | Not Met | Not Met |
| *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)** (50th Percentile) | Not Met | Met | Met | Not Met | Met |
| *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* (50th Percentile) | Not Met | Met | Met | Not Met | Met |
| *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* (75th Percentile) | Not Met | Not Met | Met | Met | Met |
| *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* (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%—Total* (75th Percentile) | Not Met | Not Met | Not Met | Met | Not Met |
| *Medication Management for People With Asthma—Medication Compliance 75%—Total* (75th Percentile) | Met | Not Met | Not Met | Met | Met |

| Measure | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI |
|---|---|---|---|---|---|
| **Behavioral Health** | | | | | |
| *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* (75th Percentile) | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* (75th Percentile) | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| **Utilization and Health Plan Descriptive Information** | | | | | |
| *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total** (90th Percentile) | Not Met | Met | Met | Not Met | Not Met |
| **Total MQD Targets Met** | **1** | **4** | **10** | **3** | **4** |
| **Percent MQD Targets Met** | **8.33%** | **33.33%** | **83.33%** | **25.00%** | **33.33%** |

** For this indicator, a lower rate indicates better performance.*

*Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.*

All five health plans had reportable rates for the 12 measures with MQD Quality Strategy targets. KFHP QI met or exceeded 10 (83.3 percent) of the MQD Quality Strategy targets, followed by HMSA QI and UHC CP QI, which met or exceeded the MQD Quality Strategy targets for four measures (33.3 percent). 'Ohana QI met or exceeded three (25.0 percent) of the MQD Quality Strategy targets, while AlohaCare QI only met one (8.3 percent) of the targets. These results, in combination with overall HEDIS measure rates, suggest considerable room for improvement for AlohaCare QI, HMSA QI, 'Ohana QI, and UHC CP QI in meeting the goals outlined in the MQD Quality Strategy.

## Validation of Performance Improvement Projects

In 2018, HSAG validated two PIPs for each of the five QUEST Integration plans—AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP. The PIPs included *Getting Needed Care*, *Prenatal and Postpartum Care*, and *Medication Management for People With Asthma*. All five health plans completed PIPs related to the getting needed care topic. Four plans (AlohaCare QI, HMSA QI, 'Ohana QI, and UHC CP) completed PIPs related to prenatal and postpartum care, while KFHP QI submitted a PIP focused on improving asthma medication management because its prenatal and postpartum care rates did not demonstrate the need for a PIP. For the 2018 validation, all QI health plans progressed to testing interventions in Module 4.

HSAG validated two PIPs for 'Ohana CCS: *Improving Behavioral Health Assessment (BHA) Completion Rates* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge*. For the 2018 validation, CCS also progressed to testing interventions in Module 4.

The health plans had not progressed to reporting PIP SMART Aim measure results. At the conclusion of the PIPs in February 2019, each health plan will submit completed Module 4s, summarizing intervention evaluation results. The health plans will also submit Module 5 for each PIP with the key findings,

outcomes achieved, and lessons learned. Healthcare outcome data and health plan comparative information will be available after the Module 4 and Module 5 submissions in the 2019 validation year.

## Consumer Assessment of Healthcare Providers and Systems (CAHPS)

### *Statewide Comparisons—QI Health Plans*

Table 4-10 presents the 2018 percentage of top-level responses for each QI health plan and the QI Program aggregate.[4-4] Additionally, the QI health plans' results compared to the overall QI Program aggregate are displayed below.

**Table 4-10—Comparison of 2018 QI Adult CAHPS Results**

| | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI | QI Program Aggregate |
|---|---|---|---|---|---|---|
| **Global Ratings** | | | | | | |
| Rating of Health Plan | 64.7% | 58.5% ↓ | 71.7% ↑ | 56.8% ↓ | 63.0% | 63.1% |
| Rating of All Health Care | 56.7% | 56.3% | 60.3% | 54.3% | 55.0% | 56.5% |
| Rating of Personal Doctor | 67.5% | 62.0% | 70.5% | 66.8% | 66.2% | 66.7% |
| Rating of Specialist Seen Most Often | 72.4% | 62.6% | 68.6% | 71.1% | 66.8% | 68.2% |
| **Composite Measures** | | | | | | |
| Getting Needed Care | 84.1% | 82.1% | 83.4% | 83.9% | 83.1% | 83.4% |
| Getting Care Quickly | 78.2% | 79.5% | 82.1% | 81.8% | 85.2% | 81.8% |
| How Well Doctors Communicate | 95.4% | 91.8% | 95.4% | 92.2% | 93.2% | 93.4% |
| Customer Service | 93.3%+ | 92.6%+ | 88.5% | 87.1% | 88.0% | 89.3% |
| Shared Decision Making | 79.3%+ | 86.0% | 82.6% | 83.9% | 82.9% | 83.1% |
| **Individual Item Measures** | | | | | | |
| Coordination of Care | 88.8%+ | 85.9% | 85.6% | 80.3% | 82.3% | 84.0% |
| Health Promotion and Education | 78.8% | 77.4% | 73.4% | 80.8% | 77.2% | 77.4% |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA adult Medicaid national averages.
↑ indicates the score is statistically significantly higher than the QI Program aggregate.
↓ indicates the score is statistically significantly lower than the QI Program aggregate.
+ indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

[4-4] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI.

Comparison of the QI Program aggregate and QI health plans' scores to the 2017 NCQA adult Medicaid national averages revealed the following summary results:

- The QI Program scored at or above the national average on 10 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- AlohaCare 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*, *How Well Doctors Communicate*, *Customer Service*, *Coordination of Care*, and *Health Promotion and Education*.
- HMSA QI scored at or above the national average on seven measures: *Rating of All Health Care*, *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- KFHP QI scored at or above the national average on 10 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*, and *Coordination of Care*.
- 'Ohana QI scored at or above the national average on six measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Health Promotion and Education*.
- UHC CP QI scored at or above the national average on seven measures: *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Health Promotion and Education*.

Comparison of the QI health plans' scores to the QI Program aggregate revealed the following summary results:

- AlohaCare QI did not score statistically significantly lower or higher than the QI Program aggregate on any of the measures.
- HMSA QI scored statistically significantly lower than the QI Program aggregate on one measure, *Rating of Health Plan*.
- KFHP QI scored statistically significantly higher than the QI Program aggregate on one measure, *Rating of Health Plan*.
- 'Ohana QI scored statistically significantly lower than the QI Program aggregate on one measure, *Rating of Health Plan*.
- UHC CP QI did not score statistically significantly lower or higher than the QI Program aggregate on any of the measures.

## National Average Comparisons—Children's Health Insurance Program (CHIP)

Table 4-11 presents the 2018 percentage of top-level responses for the Hawaii CHIP population compared to the 2017 NCQA child Medicaid national averages.

**Table 4-11—Comparison of 2018 CHIP CAHPS Results**

| | |
|---|---|
| **Global Ratings** | |
| Rating of Health Plan | 72.4% |
| Rating of All Health Care | 67.9% |
| Rating of Personal Doctor | 73.2% |
| Rating of Specialist Seen Most Often | 75.3%+ |
| **Composite Measures** | |
| Getting Needed Care | 85.9% |
| Getting Care Quickly | 85.0% |
| How Well Doctors Communicate | 96.4% |
| Customer Service | 85.9%+ |
| Shared Decision Making | 79.1% |
| **Individual Item Measures** | |
| Coordination of Care | 84.2% |
| Health Promotion and Education | 78.2% |

Cells highlighted in yellow represent scores that are at or above the 2017 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2017 NCQA child Medicaid national averages.
+ indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

An evaluation of the CHIP population's scores to the 2017 NCQA child Medicaid national averages revealed the following summary results:

- The CHIP population scored at or above the national averages on seven measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- The CHIP population scored below the national averages on four measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service*.

## NCQA Comparisons—QI Health Plans

Based on the comparison of the QI Program and each of the QI health plans' three-point mean scores to NCQA's HEDIS Benchmarks and Thresholds for Accreditation, member satisfaction ratings of one (★)

to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating, as shown in Table 4-12.[4-5,4-6]

**Table 4-12—Star Ratings**

| Stars | Percentiles |
|---|---|
| ★★★★★ Excellent | At or above the 90th percentile |
| ★★★★ Very Good | At or between the 75th and 89th percentiles |
| ★★★ Good | At or between the 50th and 74th percentiles |
| ★★ Fair | At or between the 25th and 49th percentiles |
| ★ Poor | Below the 25th percentile |

Table 4-13 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 4-13—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** | ★★★★ 2.52 | ★★★★ 2.44 | ★★★★★ 2.58 | ★★★★★ 2.61 |
| **AlohaCare QI** | ★★★★ 2.54 | ★★★★★ 2.48 | ★★★★★ 2.59 | ★★★★★ 2.65 |
| **HMSA QI** | ★★★ 2.46 | ★★★★ 2.45 | ★★★ 2.51 | ★★★ 2.51 |
| **KFHP QI** | ★★★★★ 2.64 | ★★★★★ 2.48 | ★★★★★ 2.61 | ★★★★★ 2.60 |
| **'Ohana QI** | ★★ 2.41 | ★★★ 2.40 | ★★★★★ 2.59 | ★★★★★ 2.65 |
| **UHC CP QI** | ★★★★ 2.54 | ★★★ 2.40 | ★★★★★ 2.59 | ★★★★★ 2.62 |

[4-5] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2018*. Washington, DC: NCQA, August 20, 2018.

[4-6] NCQA does not publish national benchmarks and thresholds for the *Shared Decision Making* composite measure or the *Health Promotion and Education* individual item measure; therefore, these CAHPS measures were excluded from the NCQA Comparisons analysis.

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 composite measures and one individual item measure.

**Table 4-14—NCQA Comparisons: Composite Measures and Individual Item Measure**

| Plan Name | Getting Needed Care | Getting Care Quickly | How Well Doctors Communicate | Customer Service | Coordination of Care |
|---|---|---|---|---|---|
| **QI Program** | ★★ 2.38 | ★★ 2.40 | ★★★★★ 2.68 | ★★★ 2.54 | ★★ 2.39 |
| **AlohaCare QI** | ★★★ 2.41 | ★ 2.35 | ★★★★★ 2.74 | ★★★★★ 2.65+ | ★★★★ 2.50+ |
| **HMSA QI** | ★★ 2.33 | ★★ 2.39 | ★★★★★ 2.67 | ★★★★ 2.58+ | ★★ 2.41 |
| **KFHP QI** | ★★★ 2.40 | ★★ 2.41 | ★★★★★ 2.75 | ★★★ 2.55 | ★★★ 2.43 |
| **'Ohana QI** | ★★ 2.37 | ★★ 2.38 | ★★★★ 2.63 | ★★ 2.49 | ★ 2.30 |
| **UHC CP QI** | ★★★ 2.39 | ★★★ 2.44 | ★★★★★ 2.64 | ★★ 2.51 | ★★ 2.38 |
| + indicates fewer than 100 respondents. Caution should be exercised when interpreting these results. | | | | | |

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*.

- AlohaCare QI's, KFHP QI's, and UHC CP QI's member satisfaction ratings for *Rating of Health Plan* 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*.
- All of the QI health plans' member satisfaction ratings met or exceeded the 75th percentile for *How Well Doctors Communicate*.

## NCQA Comparisons—CHIP

Table 4-15 presents the overall member satisfaction ratings and three-point mean scores for the Hawaii CHIP population on each of the four global ratings, four composite measures, and one individual item measure.[4-7,4-8]

**Table 4-15—NCQA Comparisons**

| Measure | Three-Point Mean | Star Rating |
|---|---|---|
| **Global Ratings** | | |
| Rating of Health Plan | 2.68 | ★★★★★ |
| Rating of All Health Care | 2.62 | ★★★★★ |
| Rating of Personal Doctor | 2.69 | ★★★★★ |
| Rating of Specialist Seen Most Often | 2.68+ | ★★★★★ |
| **Composite Measures** | | |
| Getting Needed Care | 2.41 | ★★ |
| Getting Care Quickly | 2.51 | ★ |
| How Well Doctors Communicate | 2.74 | ★★★★ |
| Customer Service | 2.46+ | ★ |
| **Individual Item Measure** | | |
| Coordination of Care | 2.42 | ★★★ |

+ indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

The NCQA comparisons revealed the following summary results:

- The CHIP population 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*.
- The CHIP population scored at or between the 75th and 89th percentiles on one measure, *How Well Doctors Communicate*.
- The CHIP population scored at or between the 50th and 74th percentiles on one measure, *Coordination of Care*.
- The CHIP population scored at or between the 25th and 49th percentiles on one measure, *Getting Needed Care*.

[4-7] NCQA does not publish national benchmarks and thresholds for the *Shared Decision Making* composite measure or the *Health Promotion and Education* individual item measure; therefore, these CAHPS measures were excluded from the NCQA Comparisons analysis.

[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.

- The CHIP population scored below the 25th percentile on two measures: *Getting Care Quickly* and *Customer Service*.

# Provider Survey

## *Plan Comparisons*

Table 4-16 presents a summary of the statistically significant differences in performance that existed between the QI health plans' 2018 top-box rates (i.e., percent satisfied).

**Table 4-16—Plan Comparisons**

| | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI |
|---|---|---|---|---|---|
| **General Positions** | | | | | |
| Compensation Satisfaction | ↑ | ↑ | ↑ | ↓ | ↓ |
| Timeliness of Claims Payments | ↑ | ↑ | — | ↓ | ↓ |
| **Providing Quality Care** | | | | | |
| Prior Authorization Process | — | ↑ | — | ↓ | ↓ |
| Formulary | — | ↑ | ↑ | ↓ | ↓ |
| **Non-Formulary** | | | | | |
| Adequate Access to Non-Formulary Drugs | ↓ | ↓ | ↑ | ↓ | ↓ |
| **Service Coordinators** | | | | | |
| Helpfulness of Service Coordinators | — | — | ↑ | ↓ | ↓ |
| **Specialists** | | | | | |
| Adequacy of Specialists | ↓ | ↑ | ↑ | ↓ | ↓ |
| Adequacy of Behavioral Health Specialists | ↓ | ↑ | ↑ | ↓ | ↓ |
| Availability of Mental Health Providers | — | ↑ | ↑ | ↓ | ↓ |
| **Substance Abuse** | | | | | |
| Access to Substance Abuse Treatment | — | — | ↑ | ↓ | ↓ |

↑ *Indicates the QI health plan's top-box rate is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's top-box rate is statistically significantly lower than the QI Program aggregate.*
— *Indicates the QI health plan's top-box rate is not statistically significantly different than the QI Program aggregate.*

The following is a summary of the QI health plans' performance on the 10 measures evaluated for statistical differences:

- AlohaCare QI's performance was statistically significantly higher than the QI Program aggregate on two measures: Compensation Satisfaction and Timeliness of Claims Payments; however, AlohaCare QI's performance was statistically significantly lower than the QI Program aggregate on three measures: Adequate Access to Non-Formulary Drugs, Adequacy of Specialists, and Adequacy of Behavioral Health Specialists.
- HMSA QI's performance was statistically significantly higher than the QI Program aggregate on seven measures: Compensation Satisfaction, Timeliness of Claims Payments, Prior Authorization Process, Formulary, Adequacy of Specialists, Adequacy of Behavioral Health Specialists, and Availability of Mental Health Providers; however, HMSA QI's performance was statistically significantly lower than the QI Program aggregate on one measure, Adequate Access to Non-Formulary Drugs.
- KFHP QI's performance was statistically significantly higher than the QI Program aggregate on eight measures: Compensation Satisfaction, Formulary, Adequate Access to Non-Formulary Drugs, Helpfulness of Service Coordinators, Adequacy of Specialists, Adequacy of Behavioral Health Specialists, Availability of Mental Health Providers, and Access to Substance Abuse Treatment.
- 'Ohana QI's performance was statistically significantly lower than the QI Program aggregate on all 10 measures: Compensation Satisfaction, Timeliness of Claims Payments, Prior Authorization Process, Formulary, Adequate Access to Non-Formulary Drugs, Helpfulness of Service Coordinators, Adequacy of Specialists, Adequacy of Behavioral Health Specialists, Availability of Mental Health Providers, and Access to Substance Abuse Treatment.
- UHC CP QI's performance was statistically significantly lower than the QI Program aggregate on all 10 measures: Compensation Satisfaction, Timeliness of Claims Payments, Prior Authorization Process, Formulary, Adequate Access to Non-Formulary Drugs, Helpfulness of Service Coordinators, Adequacy of Specialists, Adequacy of Behavioral Health Specialists, Availability of Mental Health Providers, and Access to Substance Abuse Treatment.

## *Trend Analysis*

Table 4-17 presents a summary of the statistically significant differences of the 2018 top-box rates compared to the corresponding 2016 top-box rates.

**Table 4-17—Trend Analysis**

| | QI Program | AlohaCare QI | HMSA QI | KFHP QI | 'Ohana QI | UHC CP QI |
|---|---|---|---|---|---|---|
| **General Positions** | | | | | | |
| Compensation Satisfaction | — | ▲ | — | — | — | — |
| Timeliness of Claims Payments | — | ▲ | — | — | — | — |
| **Providing Quality Care** | | | | | | |
| Prior Authorization Process | ▲ | — | — | — | — | — |
| Formulary | — | — | — | — | — | — |

| | QI Program | AlohaCare QI | HMSA QI | KFHP QI | ʻOhana QI | UHC CP QI |
|---|---|---|---|---|---|---|
| **Non-Formulary** | | | | | | |
| Adequate Access to Non-Formulary Drugs | ▲ | — | — | — | — | — |
| **Service Coordinators** | | | | | | |
| Helpfulness of Service Coordinators | ▲ | — | — | — | — | — |
| **Specialists** | | | | | | |
| Adequacy of Specialists | ▲ | — | — | — | — | — |
| Adequacy of Behavioral Health Specialists | — | — | — | — | — | — |
| Availability of Mental Health Providers | NT | NT | NT | NT | NT | NT |
| **Substance Abuse** | | | | | | |
| Access to Substance Abuse Treatment | NT | NT | NT | NT | NT | NT |

▲ *Indicates the 2018 top-box rate is statistically significantly higher than the 2016 top-box rate.*
▼ *Indicates the 2018 top-box rate is statistically significantly lower than the 2016 top-box rate.*
— *Indicates the 2018 top-box rate is not statistically significantly different than the 2016 top-box rate.*
*NT indicates that this measure was not included in the 2016 survey administration; therefore, the results for this measure are not trendable.*

The following is a summary of the QI Program and the QI health plans' performance on the eight measures evaluated for statistical differences:

- The QI Program's 2018 top-box rates were statistically significantly higher than the 2016 top-box rates on four measures: Prior Authorization Process, Adequate Access to Non-Formulary Drugs, Helpfulness of Service Coordinators, and Adequacy of Specialists.
- AlohaCare QI's 2018 top-box rates were statistically significantly higher than the 2016 top-box rates on two measures: Compensation Satisfaction and Timeliness of Claims Payments.
- HMSA QI's, KFHP QI's, 'Ohana QI's, and UHC CP QI's 2018 top-box rates were neither statistically significantly higher nor lower than the 2016 top-box rates on any measures.

# 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 (2017) as a result of the EQR activity findings for compliance monitoring, HEDIS measures, PIPs, and CAHPS surveys. 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. Plan responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

## Compliance Monitoring Review

Formal follow-up reevaluations of the health plans' corrective actions to address the deficiencies identified in the 2017 compliance reviews were carried over to 2018. The specific compliance review findings and recommendations were reported in the 2017 EQR Report of Results. As appropriate, HSAG conducted technical assistance for the plans and conducted the follow-up assessments of compliance. Four QI health plans and 'Ohana CCS were found to have sufficiently addressed and corrected their findings of deficiencies through implementation of CAPs and were found to be in full compliance with requirements during the reevaluations conducted by HSAG. KFHP QI has remaining CAP items to complete in early 2019.

## 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 2017 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*

### 2017 NCQA HEDIS Compliance Audit Recommendations

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

- Regarding the integration of behavioral health data from 'Ohana, HSAG recommended 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.

### Improvement Activities Implemented

AlohaCare QI implemented the following intervention activities to address NCQA HEDIS compliance audit findings:

- AlohaCare QI continued annual data validation steps and confirmed with 'Ohana Health Plan that they checked for valid procedure and diagnosis codes, valid members, valid coding, file size, date ranges, and providers. AlohaCare QI's Quality Improvement team, upon receipt of the Ohana data, checked the average monthly volume for any irregular spikes or dips and confirmed service from one month to the next. After loading the data into the HEDIS software (QSI), AlohaCare QI checked for unrecognized member IDs and reviewed invalid codes on the claims (CPTPx, ICDDx, HCFAPOS) and Rx (RxCategory, NDC) files to confirm that the reason for the invalid status was that the codes were not part of the HEDIS value set.
- For HEDIS 2017, Queen Emma Clinic provided data from its diabetes registry for our use in the calculation of rates. AlohaCare QI's vendor at the time, Verscend, mapped the data AlohaCare QI identified that the documentation for the mapping process had some limitations.
  - AlohaCare QI did not use Queen Emma Clinics diabetes registry as a supplemental data source for HEDIS 2018.
  - For HEDIS 2019, AlohaCare QI contracted with a vendor, Health Catalyst, which was also the vendor for Queens and hosted their data making them significantly more familiar with its structure. Queen Emma Clinics has provided approval for Health Catalyst to pull their data directly for AlohaCare QI's HEDIS reporting. Health Catalyst's knowledge of both the Queens

data layout and our HEDIS data engine (Inovalon) input specifications has helped better structure Queen Emma Clinics diabetes registry as a supplemental data source.
  - The formal documentation for this data source was detailed in HEDIS 2019 Roadmap section 5 for Queens, and the health plan believed that it was a vast improvement from what was originally submitted during HEDIS 2017 and 2018.
- Since the recommendation in 2017, AlohaCare QI has taken on the task of mapping both administrative data and supplemental data. With AlohaCare QI's change in HEDIS vendor, from Verscend to Inovalon, the team has built experience and knowledge as a result of mapping to multiple vendors.

  In order for AlohaCare QI to know what part of the data needed to be cleansed, the health plan took a two-prong approach:

  1. Mapped our data into the vendors' file layouts so that AlohaCare QI learned more about the data as it was put together, and
  2. Performed rigorous testing on the HEDIS software and review error and validation reports.

### 2017 HEDIS Performance Measure Recommendations

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 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 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)

### Improvement Activities Implemented

AlohaCare QI obtained HEDIS rates for the QUEST Integration and Medicare Advantage lines of business for Report Year (RY) 2018. The tables below reflect selected HEDIS rates for QUEST line of business for 2018 RY vs Prior Year, including Gaps in Care relative to NCQA 75th Percentile national benchmarks.

**HEDIS—2018 Report Year (RY) Data—Medicaid**

| Measure | 2017 RY % Compliant | 2018 RY % Compliant | Change from 2017 RY to 2018 RY | 75th Percentile (2018 RY Value) | Gap (2018 RY Value) |
|---|---|---|---|---|---|
| Adolescent Well Care (AWC) | 38.93 | 49.64 | +10.71 | 61.99 | **12.35** |
| Cervical Cancer Screening (CCS) | 53.77 | 48.42 | -5.35 | 65.96 | **17.54** |
| Diabetes Care (CDC) A1C <8 (CDC) | 40.43 | 40.14 | -0.29 | 55.47 | **15.33** |
| Childhood Immunizations Status (CIS) | 61.31 | 59.61 | -1.70 | 74.74 | **15.13** |
| Prenatal and Postpartum Care (PPC): | | | | | |
| *Prenatal* | 72.75 | 64.23 | -8.52 | 87.06 | **22.83** |
| *Postpartum* | 55.72 | 51.82 | -3.90 | 69.34 | **17.52** |
| Well Checks 1st 15 Months (W15) -6+visits | 67.88 | **72.75** | +4.87 | **71.29** | **(Above 75th Percentile)** |
| Well Checks Age 3-5 (W34) | 65.69 | 66.42 | +0.73 | 79.33 | **12.91** |
| Plan Cause Readmissions (PCR)* | **Observed Rate 14.40** | **Observed Rate 12.40** | -2.00 | **17.79** | **(Above 75th Percentile)** |

*Lower is better for Plan All Cause Readmissions (PCR)

**Analysis**

Although compliance increased in several areas for both Medicaid and Medicare in RY 2018 from RY 2017, it still fell short of the NCQA 75th Percentile benchmark in most areas. Medicaid Well-Child Visits in the First 15 Months (W15), 6 or more visits was at 72.75 percent which was above the 75th percentile of 71.29 percent. There were single-digit Gaps in Care (GIC) noted in Medicare ABA, CDC and MRP, which are expected to be at a minimum of two percent closer to benchmark by RY 2020 utilizing the interventions implemented in 2018. Of special note were the Observed Readmission rates for Medicaid and Medicare, both of which exceeded the benchmarks.

Although many of the barriers identified in RY 2017 still existed and were in various stages of implementation and improvement, AlohaCare QI did implement several interventions in 2018 which resulted in success stories and positive outcomes. References to these interventions are noted in the sections AlohaCare QI's goal was to remove any and all barriers that affected the provision of quality care to their members, resulting in meeting or exceeding all NCQA HEDIS benchmarks.

**Recommended 2018 Interventions and Results**

1. **AlohaCare QI continued to evaluate the structure for its Pay-For-Performance (P4P) Program to maximizes its effectiveness.**

   AlohaCare QI continued monitoring the value-based payout for providers, the payment methodology did not change from 2017 to 2018. Providers did improve for some measures; however, as demonstrated in scores exceeding the 75th percentile. Other interventions utilized by AlohaCare QI may have been responsible for this increased performance.

   ***Example:***

   Waianae Coast almost hit 100 percent of the payout in 2018 for one measure (CDC). In Quarter 4 (Q4) 2018, AlohaCare's QI staff reached out to Waianae Coast and set up a meeting to hard deadlines to close out the program in 2018. Waianae Coast responded by submitting more than 400 records which were reviewed by our QI staff for CDC compliance for the P4P incentive. In comparison, Waianae Coast completed no reviews in 2017. Therefore, the intervention of AlohaCare QI staff's proactive and aggressive outreach and review of the medical records was effective in improving provider compliance. AlohaCare QI determined that in many cases, services are being rendered by providers, but the data necessary to support performance measure calculations was not being captured.

   During 2018 there were significant changes made to the department structure as recommended in the 2017 QI Evaluation. In late August, a new Senior Director of Quality Improvement and Utilization Management was hired. She had extensive experience in leading quality teams and improving outcomes. The lead for HEDIS was replaced in October with a Manager of Performance Measures that included all Medicaid and Medicare required reporting. This manager was responsible for establishing performance targets and monitoring (scoreboard) progress throughout the year. They also facilitated Quality Improvement Teams (QITs) to analyze results and determine barriers, as well as to recommend actions to be taken by the member or provider facing teams, and other AlohaCare QI functional departments. The membership on QITs will be cross-functional and use rapid cycle improvement methodology and are not meant to be long term assignments. All QI staff were given a performance goal of actively participating in at least one QIT.

   A provider facing team was also established by hiring a QI Performance Accountability Manager and re-purposing the role of the QI Review nurses to coach the Community Health Centers and PCP with panels of 50 members or greater. The focus of this team was to furnish training and feedback regarding closing gaps in care, use of the Health Catalyst reports to target members for outreach, and

to encourage participation in the P4P incentive program. This team established strict performance expectations and required both face-to-face and telephonic meetings on all the islands.

2. **AlohaCare QI continued to work on producing accurate Gaps-in-Care (GIC) lists from AlohaCare QI's new Data Warehouse System, Health Catalyst.**

   This intervention was implemented and GIC lists were rolled out on 9/17/18. The QI nurses on the provider facing team began meeting in person or by telephone with all PCPs who had patient panels greater than 100 members to deliver and encourage use of the GIC reports. Providers have requested the ability to see their own compliance results in a scorecard format, and AlohaCare QI is currently working with Health Catalyst to implement this reporting in Q2 2019. When visiting the offices, QI nurses coached and trained both clinical and billing support to ensure encounters with members meet HEDIS criteria.

   The Q2 reporting implementation will feature a new application within Health Catalyst (i.e., Community Care) that will be populated with a data extract from Inovalon of all HEDIS measures. Community Care will provide individualized provider reports that display the current status of all trackable HEDIS measures and allowed staff to perform timely outreach to key providers based on gaps in care. Providers will also have access to the Community Care data via the AlohaCare QI provider portal.

3. **AlohaCare QI had eleven (11) Community Health Centers (CHCs) connected through a data warehouse designed to easily retrieve their EMR data. (Note: 50 percent of the AlohaCare QI membership received care through the CHCs).**

   The goal of eleven (11) CHCs was exceeded, and the following eighteen (18) CHCs were connected through AlohaCare QI's data warehouse:

   - Kalihi Palama Health Center (PCP);
   - Bay Clinic, Inc (PCP);
   - Community Clinic of Maui (PCP);
   - Hamakua Health Center (PCP);
   - Hana Community Health Center (PCP);
   - Ho'ola Lahui Hawaii/Kauai Community Health Center (PCP);
   - Kau Family Heath Center (PCP);
   - Keaau Family Health Center (PCP);
   - Ko'olauloa Community Health & Wellness Center
   - Kokua Kalihi Valley (PCP);
   - Lanai Community Health Center (PCP);
   - Molokai Ohana Health Care, Inc. (PCP);
   - Pahoa Family Health Center (PCP);

- The Wahiawa Center for Community Health (PCP)
- Waianae Coast Comp Health Center (PCP);
- Waikiki Health (PCP;
- Waimanalo Health Center (PCP);
- West Hawaii Community Health Center PCP.

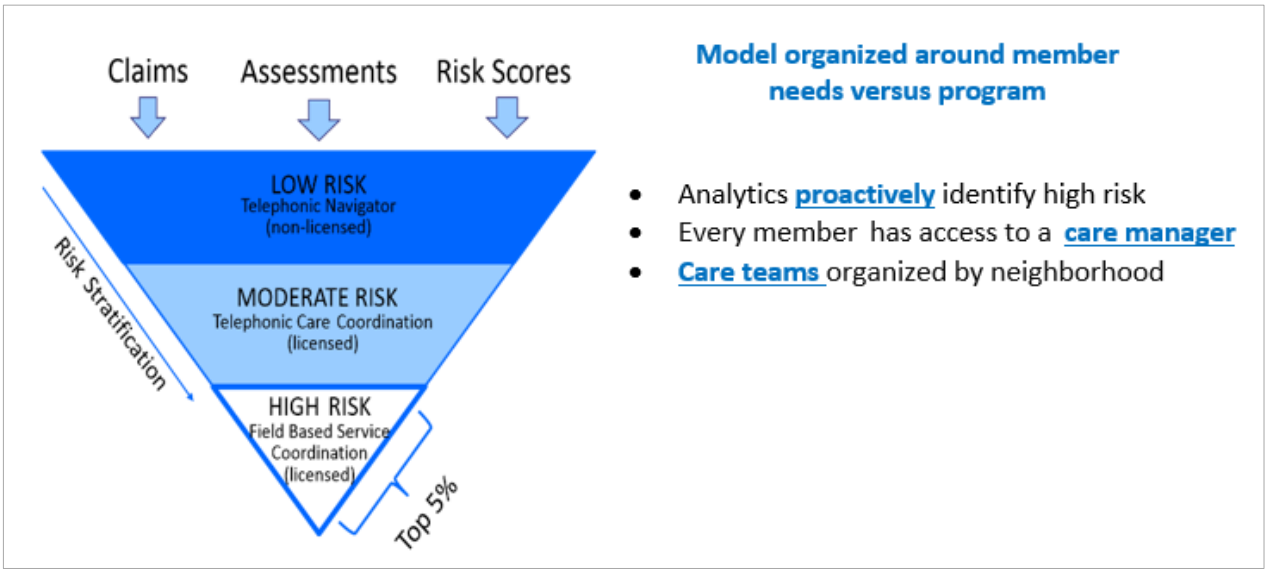
**4. The new Model of Care and Care Coordination Process, along with upgrades to AlohaCare QI's Medical Record system (G8) will allow more individualized outreach to Members and Providers to assist in closing GICs.**

The New Model of Care was implemented in 2018 and incorporated the following changes from previous model:

- Integration of care across Medicare and Medicaid (80 percent of SNP Members dually enrolled in AlohaCare QI).
- Addressed long-term service needs and not just short term/acute needs.
- Coordinated members' needs across medical, behavioral and social services, including the impact of social determinants of health.
- Based on a proactive (versus reactive) in identifying members at risk for future health care episodes and to allow early intervention to avoid or prevent escalation.

An overview of the new care model is illustrated in Figure 5-1.

**Figure 5-1—New Care Model Overview**



**Other Interventions/Performance Improvement Projects in 2018**

**1. 2018 Digital Outreach Campaigns**

In 2018 the Population Health - Quality Improvement Department contracted with HealthCrowd to implement a Digital Outreach Program with their Unified Communications Platform. The Platform coordinated the use of multiple digital modalities including SMS text and multiple level Interactive Verbal Response (IVR) phone calls, according to which modality worked best for each member. The focus for 2018 campaigns included:

- Well Care visits for Children and Adolescents,
- Childhood Immunizations,
- Prenatal and Postpartum Care, and
- Diabetes Care.

The Program proved to be effective in increasing compliance through the use of multiple digital modalities.

**2. 2018 EPSDT (Early, Periodic, Screening, Diagnostic and Treatment)**

Although AlohaCare QI's total EPSDT eligible population decreased slightly in 2018, the actual Participation Ratio did increase by one percentage point for an all-time high, reaching a **0.74 participation ratio**. This ratio fell slightly short of our 2018 goal of 0.75. Text message and Interactive Voice Response (IVR) call reminders were sent to parents of Members under age 18, and directly to Members 18 years old and above. This new *Digital Outreach Initiative* was implemented in July 2018. Outreach analysis shows that out of 8,435 members who did not attend a well-child visit in CY 2017, 1,750 members did attend a well-child visit in CY 2018 after receiving the Digital Outreach intervention. This increase represented 21 percent of the population who were historically noncompliant for their annual well-child visit.

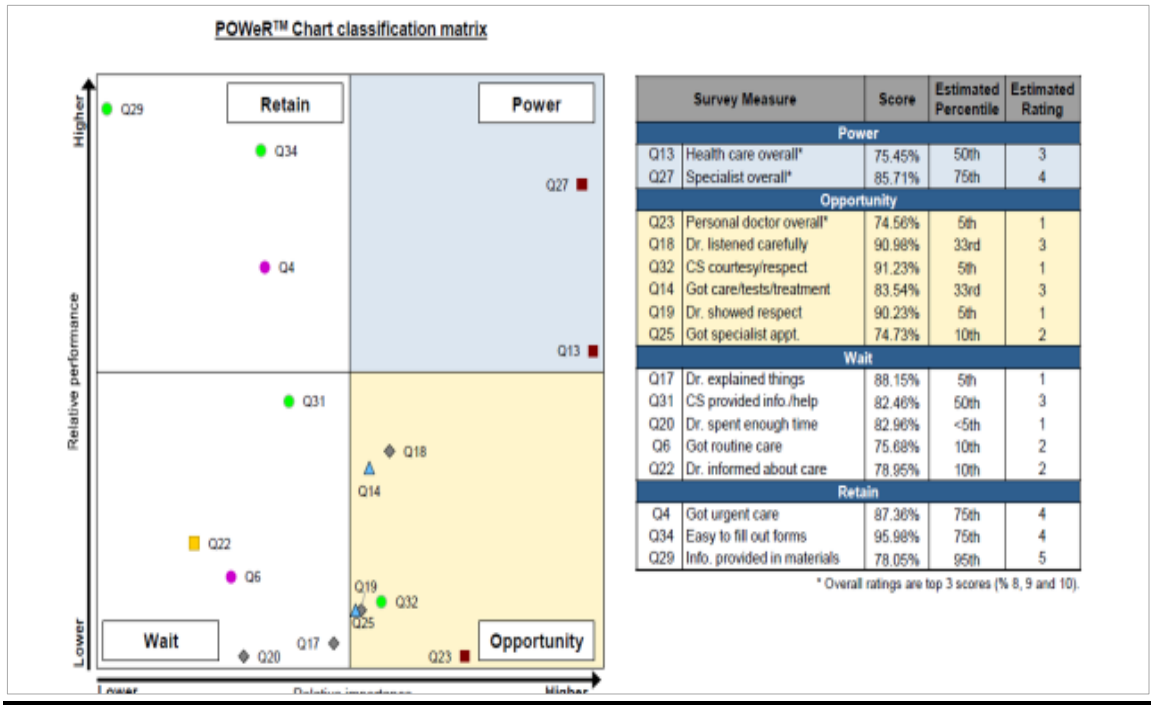
## *CAHPS—Adult Survey*

### 2017 Recommendations

Based on a comprehensive assessment of AlohaCare QI's CAHPS results, four priority areas for improvement were identified: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Coordination of Care*.

### Improvement Activities Implemented

AlohaCare QI utilized the DSS Key Driver Statistical Model to better understand the survey data results and found that, overall, AlohaCare QI performed similar to previous years.




| Survey Measure | | Score | Estimated Percentile | Estimated Rating |
|---|---|---|---|---|
| **Power** | | | | |
| Q13 | Health care overall* | 75.45% | 50th | 3 |
| Q27 | Specialist overall* | 85.71% | 75th | 4 |
| **Opportunity** | | | | |
| Q23 | Personal doctor overall* | 74.56% | 5th | 1 |
| Q18 | Dr. listened carefully | 90.98% | 33rd | 3 |
| Q32 | CS courtesy/respect | 91.23% | 5th | 1 |
| Q14 | Got care/tests/treatment | 83.54% | 33rd | 3 |
| Q19 | Dr. showed respect | 90.23% | 5th | 1 |
| Q25 | Got specialist appt. | 74.73% | 10th | 2 |
| **Wait** | | | | |
| Q17 | Dr. explained things | 88.15% | 5th | 1 |
| Q31 | CS provided info./help | 82.46% | 50th | 3 |
| Q20 | Dr. spent enough time | 82.96% | <5th | 1 |
| Q6 | Got routine care | 75.68% | 10th | 2 |
| Q22 | Dr. informed about care | 78.95% | 10th | 2 |
| **Retain** | | | | |
| Q4 | Got urgent care | 87.36% | 75th | 4 |
| Q34 | Easy to fill out forms | 95.98% | 75th | 4 |
| Q29 | Info. provided in materials | 78.05% | 95th | 5 |

* Overall ratings are top 3 scores (% 8, 9 and 10).

The opportunities for improvement identified included:

- Ease of getting care, tests or treatment
- Personal doctor listened carefully
- Personal doctor showed respect
- Rating of personal doctor
- Get appointment to see specialist as soon as needed
- Customer service treated member with courtesy and respect

The Member Services Manager was named a champion of the improvement project. The DSS report listed potential actions per question. The questions in blue ink related to providers-suggested interventions where feedback is given to the doctors as well as communication tools. The items in red ink related to health/drug plan-suggested interventions and was targeted for feedback/remediation.

**2018 Interventions:**

AlohaCare QI did initiate a team to review and develop plans to improve CAHPS. As mentioned before, AlohaCare QI is instituting a PIP to better understand the barriers to accessing specialty care. Health plan staff plan to use CAHPS data to ensure that its processes do not create barriers to specialty care. The provider relations staff will then share the CAHPS results in discussions with providers and through AlohaCare QI provider newsletters. The results were somewhat contradictory, and our provider relations team will need to identify common themes. As noted earlier, the Medicare and Medicaid populations have different perceptions of AlohaCare QI's providers' ability to give clear explanations. Over the past year, AlohaCare QI has had success contracting scarce specialty providers through improved

credentialing processes, improved communications with the health plan, increased compensation levels, telehealth possibilities, and the willingness of specialists to travel from Oahu to other islands to see members. Specialist providers, at times, have told us that our members miss appointments too often, so our goal continues to be to develop strategies in our new Care Coordination model to decrease the no show rate by reminding members of these appointments.

Member Services staff were given feedback about the surveys and additional training was given to allow staff to resolve issues in one call. In 2018, we were able to obtain technology that will be implemented in Q1 2019 that allows staff to listen back to their own calls. This will enhance our audits and allow for real time feedback. AlohaCare QI was also exploring technology that would allow it to initiate a short satisfaction survey before the caller finishes the interaction with AlohaCare QI.

The issues with member and doctor communications was explored with the quality team at the Hawaii Primary Care Association. This team worked with the CHCs to improve access and care. It was identified that there was a need for members to learn how to communicate with their doctors. A poster, displayed in the CHCs and PCP offices, was subsequently designed and distributed by the QI provider facing team. Feedback was positive, and many offices have asked for multiple copies so that they can be placed in each exam room. The poster is shown below:

# HMSA Quest Integration (HMSA QI)

## *Validation of Performance Measures*

### 2017 NCQA HEDIS Compliance Audit Recommendations

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

- 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.

### Improvement Activities Implemented

HMSA QI implemented the following intervention activities to address NCQA HEDIS compliance audit findings:

- Updated the Medical Record Review process – The abstraction team worked with Provider Relations to gather the necessary medical records. Although HMSA QI had some difficulty in obtaining some of the records, HMSA QI did not miss the NCQA MRRV deadline for record submission.
- Updated IS Grid process – HMSA QI worked internally on ensuring that responses are timely.

### 2017 HEDIS Performance Measure Recommendations

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 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 (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

### Improvement Activities Implemented

**Adult Access to Care**

HMSA QI's Online Care (HOC) initiative offered members an alternative source of care with 24/7 telephone or web access to providers. HOC continued to expand and provide innovative services to members, including web consultations and follow-up appointments for certain specialties.

Another option available to members that facilitated improvement in access to care was incorporating urgent care providers located in clinics on Oahu, Maui, Hawaii Island, and Kauai. The urgent care clinics offered extended weekday hours, weekend and holiday hours, and treated a wide range of conditions, except life-threatening emergencies.

HMSA QI also continued to provide member education materials, such as articles in our quarterly member magazine or line of business specific newsletters, that increased member awareness of their care options and helped members understand their role in obtaining appropriate care in a timely and satisfactory manner.

**Payment Transformation**

In 2018, HMSA QI expanded the Payment Transformation (PT) program, a reimbursement model that moved away from fee-for-service (FFS) payment to a per member per month (PMPM) payment for nearly all services rendered by Primary Care Providers (PCPs). Since the inception of the PT program, quality care from a care gaps perspective has continued to increase for the majority of the measures in the program. The following measures were included in the program:

- Childhood Immunization Status
- Immunizations for Adolescents
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Comprehensive Diabetes Care
- Controlling High Blood Pressure

**Children Preventative Care**

Children received immunizations when they visit the doctor to receive other childhood preventive services. For this reason, HMSA QI sent mailers containing immunization and preventive service information to parents of children aged 6 and 15 months. These mailers were tied to the child's age instead of their immunization status, which was frequently unknown. For HMSA QI, the mailers included a well-child message and immunization schedule embedded on the same page.

**Women's Health**

The HMSA QI Pregnancy Support Program (PSP) paired pregnant members with a maternity RN for telephonic education and referrals. RN support was intended to complement and encourage regular prenatal and postpartum care. The program RN maintained contact with the member from enrollment through the first month after delivery. Additionally, HMSA QI partnered and worked closely with participating Federally Qualified Health Centers (FQHCs) to identify newly diagnosed pregnant members and offer additional resources. The PSP information was included in the Winter 2018 and Summer 2018 issues of the HMSA QI-published Island Scene Magazine which was sent to all HMSA QI households.

**Care for Chronic Conditions**

Informational themed mailings directed at a topic related specific chronic conditions including diabetes, cardiovascular disease and hypertension were mailed to members, and posted to the provider resource center for providers who wanted to distribute Well-Being Resource program support materials to their patients. Members identified as being higher risk (i.e., Group 2 and Group 3) were referred to HMSA QI's Service Coordination team for individualized special health care needs (SHCN) follow-up.

**Behavioral Health**

HMSA QI's behavioral health partner, Beacon, utilized an integrated health approach to improve behavioral health outcomes by reaching out to both members and their providers involved in their care.

Beacon's key activities entailed provider and member education surrounding HEDIS Behavioral Health measures and the distribution of provider and member materials. Provider education was conducted through the distribution of educational materials for providers and members. Beacon's Psychiatric Decision Support Line was also promoted to providers as a resource to facilitate consultation with a Beacon board-certified psychiatrist.

## *CAHPS—Adult Survey*

### 2017 Recommendations

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*.

## Improvement Activities Implemented

In 2018, HMSA QI implemented a variety of activities to address each of the CAHPS composite areas below:

### Customer Service

In 2018, HMSA QI Call Center staff were consolidated into the HMSA corporate Customer Relations department. The purpose of this transition was to streamline systems and process, maximize resources, and improve performance. Through performance improvement, HMSA QI was looking to facilitate an increase in members' satisfaction with the health plan.

### Getting Care Quickly

HMSA QI provided ongoing educational materials to improve member perception and expectations regarding access to care. Newsletters were sent in 2018 to all QI members and included articles addressing:

- How to Find a Doctor
- What is a PCP versus Specialist
- When Referrals are Needed
- Appointment Access/Wait Times
- How to Access HMSA QI's Online Care

### Coordination of Care

HMSA QI continued to enhance its PCP PT program which moved away from the current fee-for-service payment model to a per-member-per-month payment, with potential additional payments for patient engagement, quality performance, and the total cost of care.

A web-based tool called, Coreo, enabled PT program participants to manage their patient panels; work their care planning registries to close care gaps; submit supplemental data, view their baseline and quarterly performance on quality metrics; engage patients in scheduling appointments; and provide automated reminders, alerts, and secured messaging.

HMSA QI administered a quarterly survey to members with an assigned PCP participating in the PT program to measure member satisfaction regarding their access to care and shared decision making. The 2018 survey results were as follows:

- 97 percent of members agreed it was easy to get the care, tests, or treatment needed.
- 92 percent of members were able to meet with his/her PCP within 24 hours when care was needed right away.
- 86 percent of members felt his/her PCP was informed and up-to-date about care received from other specialists.

- 98 percent of members agreed that taking an active role in their care was the most important part of improving his/her own health.

Through the ongoing evolution of the PT program, HMSA QI will continue to support the patient-physician relationship and improving the quality of care and service provided to members.

# Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

## *Validation of Performance Measures*

### 2017 NCQA HEDIS Compliance Audit Recommendations

Based on KFHP QI's data processing procedures, no areas of opportunity were noted.

### 2017 HEDIS Performance Measure Recommendations

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 one domains of care—i.e., Care for Chronic Conditions. HSAG recommended 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)

### Improvement Activities Implemented

The following table depicts the 3-year trend results for *Medication Management for People with Asthma* measure recommended for improvement. HEDIS 2018 results indicated that improvement was achieved during the 2017 measurement period.

| | HEDIS 2016 Rate | HEDIS 2017 Rate | HEDIS 2018 Rate |
|---|---|---|---|
| **Medication Management for People With Asthma (mma)** | | | |
| *Total Medication Compliance 50%* | 35.75% | 42.02% | 48.89% |
| *Total - Medication Compliance 75%* | 15.46% | 18.59% | 28.08% |

KFHP QI noted continued improvement in both the 50 percent compliance rate and the 75 percent compliance rate over the past three years. In 2018, KFHP QI evaluated the barriers and the activities implemented as part of its Quality Improvement process to identify appropriate improvement actions:

## Barriers

- The specifications for this measure are complex which makes it very difficult to obtain the data needed to create an actionable report of non-compliant members

## Activities

- KFHP QI continued the quality initiative of clinical pharmacists and specialists targeting patients who were not compliant or at target.
- Kaiser clinical pharmacists and pharmacy technicians proactively conducted monthly outreach targeting members ages 5-64 from hub clinic locations with an asthma medication ratio of less than 0.5. Member education focused on appropriate use of controller medication vs rescue inhaler, timeliness of refills, proper use of device, and general asthma education.
- MD specialists performed chart reviews and sent notice to Primary Care Practitioners (PCPs) to try and educate members regarding asthma management.

The following table depicts the 3-year trend results for *Antidepressant Medication Management* measure. HEDIS 2018 results indicated that improvement was achieved during the 2017 measurement period.

| Antidepressant Medication Management (AMM) | HEDIS 2016 Rate | HEDIS 2017 Rate | HEDIS 2018 Rate |
|---|---|---|---|
| *Effective Acute Phase Treatment* | 53.51% | 44.75% | 48.50% |
| *Effective Continuation Phase Treatment* | 38.16% | 28.79% | 34.96% |

KFHP QI noted improvement has been seen in both the effective acute phase treatment rate and the effective continuation phase treatment rate. In 2018, KFHP QI evaluated the barriers and the activities implemented as part of its Quality Improvement process to identify appropriate improvement actions:

## Barriers

- KFHP QI noted a slow response from members to initial outreach calls and low completion rate of program.

## Activities

- KFHP QI implemented the Depression Care Management initiative in April of 2017. This program was based on population management principals where an RN reached out to members with a depression diagnosis and new start of medication to monitor progress and assist with side effects. The RN worked with a psychiatrist to provide medication monitoring and titration based on protocol.

The following table depicts the 3-year trend results for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure. HEDIS 2018 results indicated that improvement was achieved during the 2017 measurement period.

| Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd) | HEDIS 2016 Rate | HEDIS 2017 Rate | HEDIS 2018 Rate |
|---|---|---|---|
| | 83.70% | 73.33% | 85.00% |

KFHP QI noted improvement has been seen in the *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate. HEDIS 2018 rate was 85.00 percent and above the 75-percentile threshold for HEDIS 2018. In 2018, KFHP QI evaluated the barriers and the activities implemented as part of its Quality Improvement process to identify appropriate improvement actions:

**Barriers**

- KFHP QI noted that members were not responding to outreach requests made by QUEST RNs, as well as members were stating that he/she would complete the requested lab but does not follow through with the blood draw.

**Activities**

- KFHP QI staff conducted proactive chart review was performed by QUEST RNs. The RNs outreached to the physician for a lab test and ordered one if it wasn't currently on file.

  KFHP QI staff conducted proactive outreach to members to remind them to have the lab test completed at a Kaiser lab. Staff also conducted periodic chart review after member contact to confirm member completed lab test. If the lab test was not done, KFHP QI staff continued outreach via telephone, letter and possibly through secure email to ensure a completed lab result was received.

## *CAHPS—Adult Survey*

### 2017 Recommendations

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*.

### Improvement Activities Implemented

KFHP QI addressed *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*, in the following ways:

**Getting Needed Care**

- Continued to work on the referral-based online scheduling capability to enhance and streamline the patient online scheduling experience via kp.org.

- Ensuring that KFHP QI met the need for consult appointments by standardizing the process to include first touch telephone consults, when appropriate, and making consult appointments available due to patient cancellations.
- Exploring the feasibility of video visit technology for certain specialties, select visits, and diagnosis.
- Continued recruitment of neighbor island provider resources to improve access on those islands.

**Getting Care Quickly**

- All Primary Care routine same day appointments are available for members to schedule online via KP.org.
- Women's health visits, Medicare wellness physicals, Sports Medicine, and PT appointments are also available for online booking via KP.org.
- Continued work on improving the efficiencies of our centralized Appointment Call Center on Oahu and Neighbor Islands.

**Customer Service**

- A Quality Assurance program was implemented to review calls and provide feedback to Customer Service Representatives (CSR). At least 5 to 6 calls per CSR are randomly selected and evaluated every month. These reviews raised awareness on providing quality service.
- Training sessions were conducted, as needed, to educate CSRs regarding changes to benefits and/or processes.

# 'Ohana Health Plan QUEST Integration ('Ohana QI)

## *Validation of Performance Measures*

### 2017 NCQA HEDIS Compliance Audit Recommendations

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

- While errors identified during primary source verification of the nonstandard 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 nonstandard 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.

### Improvement Activities Implemented

'Ohana QI has implemented expanded medical record overreads by two clinicians who review 100 percent of all iHOP entries. Individual healthcare markets conducted 100 percent over read (by a clinician) of all pseudo-claim data entries, in addition to conducting a 10 percent overread on a sample of pseudo-claims.

### 2017 HEDIS Performance Measure Recommendations

Most of '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 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 (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

### Improvement Activities Implemented

The following are improvement activities that were implemented or continued in 2018:

- Quality Practice Advisors (QPA) completed provider visits to educate on HEDIS and how to bill and document appropriately to capture HEDIS information. QPAs distributed care gap.

- Enhanced Pay-for-Quality (P4Q) was offered to providers to incentivize to close care gaps.
- Educated providers on submitting medical record and information to close care gap via the provider portal.
- Increased partnership with providers, facilities and lab vendors to exchange EMR data and flat files.
- Care Gap Coordinators (CGC) conducted outreach calls to members to schedule member appointments and validated whether member attended appointments.
- Disease management nurses outreached members with diabetes to provide health coaching.
- 'Ohana QI completed several interventions to educate and assist members with scheduling appointments with their doctor including: Centralized Telephonic Outreach (CTO), Inbound Care Gaps (done by Customer Service), and Service Coordination Care Gap programs.
- Periodicity letters were mailed out to members reminding them of preventive screenings that were due and to schedule an appointment with their doctor.
- Medical records were retrieved and entered as supplemental data.
- Partnered with Community Case Management Agencies (CCMAs) to close the care gaps for foster home members; provided the CCMAs with a scorecard.
- Notifications were mailed to members' PCPs following a hospital discharge; prior authorizations were used to identify these members.
- Partnered with large low-income housing, implemented reward program for care gap closures.
- Service Coordinators reviewed members care gaps and provided a Preventive Healthcare Checklist to the members.
- Contracted with a vendor to provide diabetic retinopathy testing on outer islands.
- Implemented the Utilization of the Prescription tracking tool—i.e., RxEffect.
- Aligned Quality/Raps programs.
- Enhanced Provider-specific reporting.
- Worked to increase the performance of engaged PCP's and removed physicians unwilling to engage.
- Initiated increase use and implementation of value-based contracts.
- 'Ohana QI utilized the Hawaii Immunization Registry (HIR) for data mining of child immunizations.
- Implemented Healthy Rewards for the Medicaid membership where members received rewards for timely prenatal, postpartum, well-child checks and immunizations.

## *CAHPS—Adult Survey*

### 2017 Recommendations

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*.

## Improvement Activities Implemented

The following are improvement activities that were implemented or continued in 2018:

- Provided on-going/periodic CSR service training, open discussions, and refresher programs, including:
  - Staff training to improve customer service by helping them understand words or phrases to use or not to use, issue resolution, and addressing adjacent issues.
  - Presentation at department meeting regarding on-going/periodic CSR service training, open discussions, and refresher programs.
  - Activities on the following CAHPS measures: Getting Needed Care, Getting Needed Care Quickly and Health Plan Customer Service. Provided on-going/periodic CSR service training, open discussions, and refresher programs.
  - Educational mailings emailed to the team for their review to help improve quality.
  - Engaged staff in understanding the CAHPS measures and the role each person has in affecting the scores.
  - Engaged staff in understanding member/customer basic service expectations.
  - Customer Service agents created a personal commitment statement that they will display at their desk.
  - Customer Service agents nominated themselves if they feel they have provided outstanding service. The Leadership team then reviewed the calls that were submitted and chose a winner for the week.
- Acknowledged and/or rewarded service performance/behaviors reflective of service excellence, including:
  - Financial Rewards utilized for staff performing excellent customer service.
  - Training on the importance of closing Care Gaps and a monthly challenge to schedule the most care gap appointments and reward the winning team.
  - Star Performer Awards given out Monthly, Quarterly and Annually—i.e., Highest Quality Average, Most 100% Calls with No Coaching, Most Care Gaps Closed.
  - Mahalo Line Recognition, Everyday Champions, and My Rewards designed to acknowledge and/or reward service performance/behaviors reflective of service excellence.
- Identified QI opportunities via staff observational walkthrough of calls and discussion of the member experience.
  - Quality Auditor increased the number of quality audits to 6 audits once per quarter
  - Reviewed quality audit calls with agents during their 1:1 meetings and provided coaching to help them understand the correct process.
- Developed/implemented protocols and scripts (“talking points”) to ensure consistency of information provided to your members and patients.

  - Ensures that agents provided consistent information to members. ‘Ohana QI consistently worked with the team to ensure that they had the documentation necessary for agents to handle calls efficiently and consistently.
- Assigned subject matter experts to respond to urgent or complex types of calls, questions or issues.
  - Assistance Button Requests, Live monitoring.
  - Access To Care Multidisciplinary Committee Meetings
  - Updating the Access To Care Workflow to Provide Faster Results.
- Established measurable performance/service standards (i.e., call satisfaction, call resolution, time on hold, etc.).
  - The following call center statistics were established:
    - Abandoned Rate < 5 percent
    - Service Level 80 percent of calls answered with 30 Seconds,
    - AHT < 660,
    - Quality—i.e., 92 percent of agents scored on CSAT and FCR.
- Analyzed calls using Clarabridge Speech Analytics Software to identify issues with access to care specifically—i.e., finding a provider and authorization status
- Provider Relations monitored providers for timely access and to educate as needed.
- Provider Relations educated and administered a P4P (pay for performance) program designed to reward providers for gap closures.
- Provider Relations met with the community regularly to share information and updates about our plan. They also reviewed the providers member panels for accuracy.

# UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

## *Validation of Performance Measures*

### 2017 NCQA HEDIS Compliance Audit Recommendations

Based on UHC CP QI’s data processing procedures, no areas of opportunity were noted.

### 2017 HEDIS Performance Measure Recommendations

Most of 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 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 (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)

### Improvement Activities Implemented

The following activities were implemented by the UHC CP QI in 2018 to address all key HEDIS measures, including those that fell below the national Medicaid 25th percentile in 2017:

UHC CP QI's Clinical Practice Consultants (CPCs) collaborated with providers and office staff to identify members who had open gaps in care, provided education and guidance on targeted initiatives, and discussed strategies to engage members. Provider Quality conferences took place in Hilo in Q4 2018 to address high-priority HEDIS measures. The Community Plan Primary Care Professional Incentive (CP-PCPi) program, which offers financial bonuses to PCPs for their patients' gaps in care closures, was ongoing in 2018 and expanded to include more Medicaid participating providers. In Q3 2018, the Critical Incident Registered Nurses conducted two "Quality Merienda" trainings that provided HEDIS measures refreshers to both our Oahu and neighbor island Complex Case Management Agencies (CCMA). Inter-departmental "Fast and Furious" training sessions were provided to UHC CP QI staff on HEDIS measures. UHC CP QI continued to partner with Welltok/Silverlink to conduct IVR (Interactive Voice Response) call outreach to members to address key HEDIS measures. Analysis was conducted on the effectiveness of live calls versus the IVR calls and deemed IVR outreach more effective for UHC CP QI Medicaid members. The Clinical Transformation Consultants on the Accountable Care team continued to work with contracted providers on Value-Based Contracts that address quality measures.

The 2018 activities below address the specific HEDIS measures that fell below the national Medicaid 25th percentile for the QI population in 2017:

**Access to Care**

UHC CP QI implemented the following interventions for the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* (three rates) measure.

- Welltok/Silverlink conducted IVR call outreach to members to provide education, reminders, and address the AAP measure.

- Through the Advocate4Me delivery model, Member Services Advocates assisted members with appointment scheduling and facilitating transportation services. Through the Appointment Setting Campaign, Member Services Advocates are alerted if a member is due for preventive care or other important healthcare visits.
- In the Member Handbook, members are informed of the timeframes within which they can expect to get an appointment for primary care services, as well as for specialty and behavioral health (BH) services. These access standards were reinforced to the top 10 providers not meeting them during a face-to-face provider education session.
- UHC CP QI participated in the 2018 Member Rewards Program, which incentivized members with a $10 gift card to various retailers for timely closure of certain open gaps.
- The monthly LogistiCare (transportation vendor) report was shared with UHC CP QI Service Coordinators and the BH team so that they could follow up with members who did not show up for scheduled transportation services to appointments.
- In late 2018, UHC CP QI completed the evaluation of our Health Disparities Action Plan, which addressed some of the barriers for AAP. Since then, UHC CP QI has transitioned the Health Disparities Action Plan to widen the scope of addressing and reducing healthcare disparities by proceeding with the NCQA Multicultural Healthcare (MHC) distinction process.

UHC CP QI implemented the following interventions for the *Children and Adolescents' Access to Primary Care Practitioners (CAP)* (four rates) measure.

- Throughout 2018, the CPCs established and developed relationships with pediatricians through engagement in the CP-PCPi program.
- Welltok/Silverlink conducted IVR outreach calls to members to provide education and reminders on the importance of well-child visits.
- UHC CP QI participated in the 2018 Member Rewards Program, which incentivized members with a $10 gift card to various retailers for timely closure of certain open gaps.
- UHC CP QI also participated in the UnitedHealthcare Baby Blocks program, a web-based, mobile tool that rewards pregnant members and infant members up to 15 months for attending and tracking provider visits for prenatal, postpartum, and well-child care.

## Children's Preventive Care

UHC CP QI implemented the following interventions for the following measures: Adolescent Well-Care Visits(AWC), Childhood Immunization Status (CIS) (seven rates), Immunizations for Adolescents (IMA) (three rates), Well-Child Visits in the First 15 Months of Life (W15) (one rate), and Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34).

- UHC CP QI participated in the 2018 Member Rewards Program, which incentivized members with a $10 gift card to various retailers for timely closure of open gaps, including W34 and AWC.
- Throughout 2018, the CPCs established and developed relationships with pediatricians through engagement in the CP-PCPi program.

- Welltok/Silverlink conducted IVR call outreach to members to provide education, reminders, and address AWC, W15, and W34.
- UHC CP QI's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) R.N. engaged the pediatric population through various activities, such as working with complex cases, mail-outs for welcome and birthday postcards and delinquent notifications, and education through community events.
- The EPSDT R.N. also engaged providers through outreach calls and face to face training sessions that emphasized the importance of timely well visits and vaccinations for their patients.
- CPCs conducted focused education with provider offices on AWC, CIS, W15, and W34.
- The health plan is working with MQD to finalize materials for VAKs (Vaccine Adherence in Kids) program (with Pfizer). This is a reminder program for vaccinations that targets parents of children at ages six months, eight months, and 16 months. There is also a well visit reminder for the first-year checkup that targets parents of children at 10 months of age. Target implementation for VAKs is in early 2019.
- The UnitedHealthcare Baby Blocks program rewarded UHC CP QI members for attending and tracking well-child care visits for infants up to 15 months.

**Women's Health**

UHC CP QI implemented the following interventions for the following measures: *Cervical Cancer Screening (CCS)* and *Prenatal and Postpartum Care (PPC)* (one rate).

- UHC CP QI's 2018 PIP focused on PPC rates in Hawaii County:
  - In Q2 and Q3, UHC CP QI partnered with five obstetric providers in Hawaii County to engage members due for prenatal and postpartum visits through support and education from our Community Health Worker (CHW).
  - In Q4, UHC CP QI partnered with the Women, Infants, and Children (WIC) office in Hilo to have WIC identify and inform pregnant UHC CP QI members about the Hapai Malama pregnancy program.
- UHC CP QI participated in the 2018 Member Rewards Program, which incentivized members with a $10 gift card to various retailers for timely completion of their PPC postpartum care visit.
- In late 2018, UHC CP QI completed the evaluation of our Health Disparities Action Plan. To continue to address and reduce health care disparities, UHC CP QI began the application process for the NCQA Multicultural Healthcare (MHC) distinction. UHC CP QI will include an analysis on the PPC measure to explore the impact of member language on receiving timely prenatal and postpartum care and whether any disparities exist.
- Throughout 2018, the CPCs established and developed relationships with obstetricians through engagement in the CP-PCPi program.
- Implemented IVR calls for PPC by partnering with Welltok/Silverlink.
- CPCs conducted focused education with provider offices on PPC.
- UHC CP QI conducted email reminders on the yearly wellness exam for cervical cancer screening.

- UnitedHealthcare Baby Blocks program information was sent to members as part of the annual women's health email initiative. The program rewarded members for completion and tracking of prenatal, postpartum, and well-child care visits for their infants up to age 15 months.

## *CAHPS—Adult Survey*

### 2017 Recommendations

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*.

### Improvement Activities Implemented

UHC CP QI addressed recommendations as follows:

**Getting Needed Care**

- In Q1 2018, the provider directory search function on myuhc.com transitioned to a new platform, RallyConnect. RallyConnect's new design allows members an easier and more intuitive provider search experience, as well as allows Member Services Advocates access to assist members when they call.
  - Member Services Advocates received RallyConnect training that included how to direct members to utilize the new provider directory and save provider lists for future reference.
- Efforts were made in 2018 to decrease members' frustration when errors were discovered in provider search tools, which Member Service representatives also use:
  - Q2—One FTE was hired as the Provider Roster Manager.
  - Q3—Large roster cleanse of providers' demographic data.
  - Q4 and ongoing—Review and clean-up of PCP designations.
- Through the Advocate4Me service delivery model, services provided in 2018 that were most impactful to Getting Needed Care were: clinical gap closure, immediate triage needs, decision support, facilitation of pre-authorization processes, addressing pre-authorization denials, transport service facilitation, and informational screen pop-ups for Advocates that include Health Risk Assessment (HRA) completion status needs, number of previous calls made, and health information the member may benefit from.
- The monthly LogistiCare (transportation vendor) report was shared with UHC CP QI Service Coordinators and the Behavioral Health team so that they could follow up with members who did not show up for scheduled transportation services to appointments.
- Transportation Performance Improvement efforts: In Q3 2017, the national transportation vendor contract was amended to include higher performance standards and guarantees, which were continued through 2018. These performance standards included:
  - Call center service level and abandonment rate: 80 percent of calls answered within 30 seconds or less, ≤5 percent of calls terminated prior to speaking with a live representative.

  - Transportation Satisfaction: 90 percent member satisfaction rating for all inbound/outbound calls.
  - On-time drop off: 90 percent of members are dropped off within 15 mins of scheduled arrival.
  - Missed Appointments: <1 percent of members unable to make medical appointment due to transportation failure.
- UHC CP QI's 2018 PIP focused on Getting Needed Care for BH:
  - In Q2 and Q3, BH training for the Member Services Advocates was expanded to include information on different BH provider types and their scope of service, as well as reinforcement of the services of the Optum BH Advocates. The intent of this training intervention was to improve members' experience in accessing appropriate BH services when calling into the UHC CP QI Member Call Center.
  - In Q4, CPCs and the Clinical Quality Manager provided telehealth education to PCPs and UHC CP QI's member-facing Service Coordination team.
  - Throughout Q3 and Q4, the PIP team met with UHC CP QI's CEO and CMO to discuss telehealth marketing to expand the services to providers and members, and the types of tools and resources that the health plan can provide.

**Getting Care Quickly**

- The Appointment Setting Campaign is an Advocate4Me enhancement that was initiated in Q2 2017 and was ongoing in 2018. During conversations with members, Member Services Advocates have real time access to an alert system that notifies them if a member is due for preventive care or other important healthcare visits. The Advocate can assist members with scheduling appointments through three-way calling.
- In 2018, enhancements were made to expand and ensure provider network adequacy to support members in getting care right away:
  - Q1: Provider Relations Advocates (PRAs) were retrained and roles were revised to focus more on claims and provider data issues.
  - Q1: Two contractors were hired to support UnitedHealthcare Network (UHN) Provider relationships and contracting.
  - Ongoing: PRAs developed relationships with pediatricians and OB-GYNs as part of the UHN strategy and provided education accordingly.
  - Ongoing: Monitoring of network adequacy through the quality committee reporting structure.
- In the Member Handbook, members are informed of the timeframes within which they can expect to get an appointment for primary care services, as well as specialty and behavioral health services. These access standards were reinforced to the top 10 providers not meeting them during a face-to-face provider education session.
- In 2018, UHC CP QI began the application process for the NCQA Multicultural Healthcare (MHC) distinction and focused on Getting Care Quickly to determine if any disparity existed based on race/ethnicity. The 2018 CAHPS survey indicated a racial disparity towards Asians for the Getting

Care Quickly composite question. As a result, UHC CP QI developed an action plan to address this disparity, which will be carried through 2019.

**Customer Service**

- The Pharmacy Service Model was expanded from Q3 2017 to Q2 2018 to add the enhancements listed below. The intent of the expansion was to decrease member effort and frustration from repeated calls to the Member Call Center when they were unable to obtain their prescriptions at the pharmacy.
  - Reviewed feedback and provided education to Member Service Advocates on medication requirements that had been causing member abrasion.
  - Updated training materials (on benefits, call handling, Preferred Drug List basics, referrals to Optum for clinical opportunities, and training on Optum Rx system) to provide newly hired Member Service Advocates improved information.
  - Implemented updated and more user-friendly SOPs for handling prescription-related calls.
- Enhancements to the Advocate4Me service delivery model were initiated in 2018 that added Call Quality Coaches and Advocate Advisors to the staffing model in order to aid Member Service Advocates. This has allowed Advocates to gain real-time feedback on their interactions with members and identify improvement opportunities.
- Another new Advocate4Me initiative in 2018 was Prevent A Repeat Caller (PaRC), which involved predictive modeling analytics to identify key events in each member's record that could potentially trigger multiple calls. When a member is at risk for repeat calls, a pop-up message will appear on the Advocate's screen that indicates the reasons for a potential repeat call. The Advocate is then able to attempt to resolve these issues on the first call, which has shown to impact quality scores and satisfaction positively, as the member spends less time on the phone and receives the quality information and healthcare they need.
- In Q3 2018, work began to create and deploy centralized issue management processes and capabilities to support greater Member Services Advocate accountability in resolving and managing issues within a 48-hour timeframe. A dedicated Issue Manager was assigned and is responsible for the monitoring of all created commitments and the appropriateness of activities done by Advocates to address issues, and for coaching and ensuring commitments created by Advocates are completely and accurately resolved within the 48-hour timeframe goal.
- In Q2 2018, the Get Smart webinar series was released, which expanded Member Experience materials and training to all employees. The series provided access to tools and resources to increase awareness of and to aid in understanding member experiences 'Ohana Community Care Services ('Ohana CCS)

# ‘Ohana Health Plan Community Care Services (‘Ohana CCS)

## *Validation of Performance Measures*

### NCQA HEDIS Compliance Audit Recommendations

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

### Improvement Activities Implemented

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. ‘Ohana CCS implemented the following interventions.

- Increased the number of cases to be overread by the CCS Supervisor from 10 percent to 30 percent on a monthly basis for non-standard supplemental data—i.e., the Behavioral Health Assessment (BHA).
- If the BH Supervisor identified that the BHA was not compliant, notification was sent to the member’s Community Based Case Management (CBCM) agency instructing them to appropriately complete the BHA for resubmission.
- The New Member Tracker Final, which included all CCS members enrolled between November 2 of the prior year and November 1 of the measurement year, was sent to the Corporate QI Analytics Department for processing by a Senior Technical Business Systems Analyst.
- The Senior Technical Business Systems Analyst applied enrollment criteria against the BHA Tracker and determined who remained in the denominator.
- The Senior Technical Business Systems Analyst applied logic between the enrollment date and date the BHA was completed to determine the numerator for both BHA sub-measures according to metric specifications:
  - BHA completed within 30 days of enrollment
  - BHA completed within 31-60 days of enrollment

HSAG also recommended that only data sources relevant to the measures as part of the audit scope be included in the Roadmap. ‘Ohana CCS reviewed the recommendation internally and determined to send only relevant data sources for the selected measures will be included in the Roadmap going forward.

Based on issues identified during primary source verification, HSAG recommended that procedures to track and validate data related to the BHA measure be improved. ‘Ohana CCS implemented the following interventions.

- ‘Ohana CCS updated BHA Agreements with CBCM agencies to require that BHAs were completed timely for any new members in the measurement period.
- Built a SharePoint intranet site to streamline the process and allowed access to updated tracking by the CCS department.
- Improved ‘Ohana CCS’ internal processes to include outreach to new members and same day notifications to the CBCM agency upon assignment. If a member was unable to reached, the member was auto-assigned to a CBCM agency based on geographic location.
- Service level contracts and policies were updated and implemented to address BHA measure expectations included, CCS CBCM contracts, CCS program descriptions, CCS provider audit tool, CBCM Provider Scorecard: BHA Metric, and CCS Case Manager Orientations slide deck.
- Supervisor conducted overread on 30 percent of the BHAs to ensure they included a valid date in the signature line on a monthly basis.
- ‘Ohana CCS team launched a Performance Improvement Project (PIP) for BHA to improve the completion rates and process. The SMART Aim Goal was set at 50 percent improvement from 16 percent for the selected CBCMs identified as high volume and low performers.
- ‘Ohana CCS team notified the agencies of the newly enrolled members through a follow-up email notification. Then, the agencies would conduct and complete behavioral health assessment for those new members. The intervention was implemented to ensure CBCMs were aware of the newly enrolled member in a timely fashion, and to improve the mental health outcomes by initiating the comprehensive assessment and treatment planning early.
- Although the CCS did not meet the AIM Goal of 50 percent. The intervention to send the timely notifications of new members to the agencies brought their rate closer to the goal. The completion rate for the project ended at 47 percent. The process was implemented for all CBCMs

### 2017 HEDIS Performance Measure Recommendations

Only two of ‘Ohana CCS’ QI 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 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 QI population:

- Behavioral Health
  - Antidepressant Medication Management (two rates)

- Utilization and Health Plan Descriptive Information
  - Ambulatory Care—Total (per 1,000 Member Months)

### Improvement Activities Implemented

The following improvement activities were implemented or continued in 2018:

**Behavioral Health—Antidepressant Medication Management (two rates)**

- Engaged four FQHC pharmacies for CAID related measures
- Hired a Pharmacy Manager for CCS LOB who oversees BH pharmacy related care gaps.
- Followed up with providers to verify changes were made to be more quality and adherence focused as well as compliant with HEDIS measures.
- Continued the Provider Education Program (PEP) which entailed routine provider facing meetings to address various quality- and medication-related prescribing practices.
- Identified that the pharmacy claims were not part of the State mandated health information exchange that occurs monthly between other health plans that covered the CCS members for their Quest Integration physical health coverage. The exchange program was modified to include pharmacy data for these rates to increase accuracy for all medication adherence measures.
- Access to Medication section in the CCS utilization report allowed the CCS team to identify the barriers and learn the population. The CCS pharmacist partnered with Specialty pharmacy to pilot a program to improve medication adherence for our membership. The Specialty pharmacy has benefits include medication synchronization and medication adherence outreach via phone to members, as well as strip packaging and home delivery in the effort to increase the rate of members refilling their psychotropic medication in a timely fashion.

**Utilization and Health Plan Descriptive Information**

- ‘Ohana CCS developed a reporting tool to capture the utilization of services that the CCS program offers by each island. The report contained the following sections to review and monitor:
  - Service utilizations such as inpatient and partial hospitalizations, supportive housing, supported employment, psychosocial rehabilitation, residential treatment, substance use disorder services, and representative payee.
  - Access to care is reviewed by provider type (PCP, psychiatrist, and psychologist).
  - Access to medications by number of timely refills on psychotropic medications.
  - ER visits are reviewed by island
  - Acute psychiatric admissions by percent of members who met with case managers and/or psychiatrist the week prior to admission, and rate of members who had discharge plan.

**Ambulatory Care—Total ED Visits (per 1,000 Member Months)**

- In an effort to monitor the utilization of the ED visits closely, a monthly utilization report was created and reviewed by island. This report showed the rate of members who had at least one ER visit in the past month.
- The utilization report allowed the interdisciplinary care team to collaborate and come up with action plans to execute for high ER utilizers and effective discharge planning.
- Community navigator was placed at one of our highest volume ER facilities in the State to meet with hard-to-reach members as they present to the ER to get them connected with their CCS case manager and create linkages to resources to decrease unnecessary ER utilization.

# Appendix A. Methodologies for Conducting EQR Activities

## Introduction

In calendar year (CY) 2018, 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 2017 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 2018, 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

## 2018 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, PIHP's, and PAHP'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 health plans. To complete this requirement, HSAG conducted a follow-up review of compliance with federal and State requirements for standard areas for which the QI health plans and CCS had implemented required corrective actions based on findings of deficiency from the 2017 compliance reviews. Once each health plan's final compliance review report was produced, the health plan prepared and submitted a CAP for the MQD's and HSAG's review and approval. Once the CAP was approved, the health plan implemented the planned corrective actions and submitted documented evidence that the activities were completed and that the plan was now in compliance. The MQD and HSAG performed a desk review of the documentation and issued a final report of findings once the plan was determined to meet the requirement(s) and was in full compliance.

### Technical Methods of Data Collection and Analysis

Prior to beginning the compliance monitoring follow-up reviews, HSAG developed a data collection tool to use in the review of each health plan reflecting the areas for required corrective actions. The CAP tool contained the applicable federal and/or State regulation and the action the health plan was required to take to become fully compliant.

HSAG conducted the follow-up compliance monitoring in accordance with the CMS protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-1]

### Description of Data Obtained

The health plans used the CAP tool to describe their proposed corrective action, provide the expected date of completion, and list the documents provided to demonstrate implementation of the corrective actions. HSAG assessed the health plans' compliance with federal and State requirements from a wide range of written documents provided by the health plans including committee meeting agendas and minutes, policies and procedures, monitoring reports, and delegation subcontracts and agreements.

Upon the successful completion of all CAP items, HSAG provided the health plan and the MQD with the completed CAP evaluation tool. 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 2018 validation activities. Note that the technical specifications for several measures were state-defined

[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/medicaid-managed-care/external-quality-review/index.html. Accessed on: Mar 26, 2019.

for the 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 |
| **Children's Preventive Care** | | | |
| *Adolescent Well-Care Visits* | ✓ | | Hybrid |
| *Childhood Immunization Status (Combo 3 Only)* | ✓ | | 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* | ✓ | | Admin |
| *Chlamydia Screening in Women* | ✓ | | Admin |
| *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 |

| Performance Measure | QI | CCS | Methodology |
|---|---|---|---|
| *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or 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 a Primary Care Practitioner After Hospitalization for Mental Illness (FUP)** | ✓ | | Admin |
| **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 |
| *Emergency Department Use without Hospitalization (EDUH)* | ✓ | | Admin |
| *ED Visits for Ambulatory Care-Sensitive Conditions (NYU)* | ✓ | | Admin |

* Indicates this measure is a state-specified, non-HEDIS measure.

*KFHP QI reported seven measures via the administrative methodology. These measures were Adolescent Well-Care Visits; Childhood Immunization Status; Immunizations for Adolescents; Cervical Cancer Screening; PPC–Postpartum Care; Comprehensive Diabetes Care (except the Comprehensive Diabetes Care—Blood Pressure Control [<140/90 mm Hg] 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. AlohaCare QI, HMSA QI, 'Ohana QI, and UHC CP QI reported these seven measures as hybrid.*

## Technical Methods of Data Collection and Analysis

HSAG validated the performance measures calculated by health plans for the QI population and CCS population using selected methodologies presented in *HEDIS 2018, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.* The measurement period reviewed for the health plans was CY 2017 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 worksheets 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 organization followed the specifications, but the denominator was too small (<30) to report a valid rate.<br>*a.* For effectiveness of care (EOC) and EOC-like measures, when the denominator is <30; and for *Standardized Healthcare-Associated Infection Ratio* (HAI) measure, when total inpatient discharges is <30.<br>*b.* For utilization measures that count member months, when the denominator is <360 member months.<br>*c.* For all risk-adjusted utilization measures, except PCR [*Plan All-Cause Readmissions*], when the denominator is <150. |
| *NB* | *No Benefit.* The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency). |
| *NR* | *Not Reported.* The organization chose not to report the measure. |
| *NQ* | *Not Required.* The organization was not required to report the measure. |
| *BR* | *Biased Rate.* The calculated rate was materially biased. |
| *UN* | *Un-Audited.* The organization chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., Board Certification). |

## 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 2018, 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 |

| Performance Measure | MQD Quality Strategy Target[1] |
|---|---|
| **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 |
| **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 2017.

[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 is required by the MQD to conduct performance improvement projects (PIPs) in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the BBA, HSAG, as the State's EQRO, validated

the PIPs through an independent review process. To ensure methodological soundness while meeting all state and federal requirements, HSAG follows validation guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-2] Additionally, HSAG's PIP process facilitates frequent communication with the health plans. HSAG provides written feedback after each module is validated and offers technical assistance to provide further guidance. HSAG conducts webinar trainings prior to each module submission and Module 4 progress check-ins while health plans are testing interventions. In 2018, HSAG provided one-on-one PIP technical assistance to health plans, as requested.

## Technical Methods of Data Collection and Analysis

HSAG's methodology for validating PIP findings is a consistent, structured process that provides the health plan with specific recommendations. The goal of HSAG's validation is to ensure that the health plan and key stakeholders can have confidence that the methodology is sound and reported improvement can be linked to the quality improvement activities conducted for the PIP. At the onset, HSAG provides feedback to ensure that PIPs are well-designed. Additionally, HSAG works with health plans if mid-course corrections are needed. HSAG's validation includes the following two key components:

1. Evaluation of the technical structure to determine whether a PIP's initiation (i.e., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring 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 using Plan-Do-Study-Act (PDSA) cycles. This component evaluates how well the health plan executed its quality improvement activities and whether the desired aim was achieved.

## Description of Data Obtained

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 to the point of progression. In 2017, the health plans initiated new PIPs and began the validation process by submitting Modules 1 and 2. Subsequently in 2018, the health plans continued with the PIPs, progressed

[1-2] 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/medicaid-managed-care/external-quality-review/index.html. Accessed on: Mar 26, 2019.

through Module 3, and started intervention testing in Module 4. The health plans had not yet progressed to reporting PIP outcomes.

The PIP topics are included in Table A-4.

**Table A-4—2018 Validated PIPs**

| Health Plan | PIP Topic |
|---|---|
| AlohaCare | • *Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services*<br>• *Improving Timeliness of Prenatal Care and Postpartum Care* |
| HMSA | • *Getting Needed Care*<br>• *Improving Timeliness of Prenatal Care and Postpartum Care* |
| KFHP | • *Getting Needed Care*<br>• *Medication Management for People With Asthma, Ages 5–64* |
| 'Ohana | • *Getting Needed Care*<br>• *Improving Timeliness of Prenatal Care and Postpartum Care* |
| UHC CP | • *Getting Needed Care: Improving Access to Behavioral Health Services*<br>• *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* |
| 'Ohana CCS | • *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge*<br>• *Improving Behavioral Health Assessment (BHA) Completion Rates* |

## 2018 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

### *Objectives*

The primary objective of the Adult Medicaid CAHPS survey was to effectively and efficiently obtain information on the levels of satisfaction of the Hawaii Medicaid adult members with their health plan and 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 Adult CAHPS survey and the CHIP CAHPS survey was accomplished through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult members of the QI health plans, and the CAHPS 5.0H Child Medicaid Health Plan Survey instrument (without the Children with Chronic Conditions [CCC] measurement set) to CHIP members. Adult members included as

eligible for the survey were 18 years of age or older as of December 31, 2017. CHIP members included as eligible for the survey were 17 years of age or younger as of December 31, 2017. All members (or parents/caretakers of sampled CHIP members) completed the surveys from February to May 2018 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 Surveys process allows for two methods by which members can complete a survey: mail or 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 members (or 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 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 nonrespondents, 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 one of the alternate languages. It is important to note that the CAHPS 5.0H Health Plan Surveys are 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 for Survey Measures, HSAG submitted a request for a survey protocol enhancement and received NCQA's approval to allow the plan members, or parents/caretakers of sampled CHIP members, the option to complete the CAHPS survey in the designated alternate languages.[A-3] The Adult CAHPS survey included a set of standardized items (53 questions) that assessed members' perspectives on their care. The Child CHIP 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 adult and CHIP members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. An analysis of the CAHPS 5.0H Adult and Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures. 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 (+).

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

[A-3] National Committee for Quality Assurance. *HEDIS® 2018, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2017.

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. The percentage of top-box responses is referred to as a question summary rate for the global ratings. 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 item measures 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 item measures 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 NCQA's 2018 HEDIS Benchmarks and Thresholds for Accreditation, except for the *Shared Decision Making* composite measure and the *Health Promotion and Education* individual item measure.[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 determined for each CAHPS measure, with one being the lowest possible rating and five being the highest possible rating, using the following percentile distributions:

[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 2018*. Washington, DC: NCQA, August 20, 2018.

| | |
|---|---|
| ★★★★★ | indicates a score at or above the 90th percentile |
| ★★★★ | indicates a score at or between the 75th and 89th percentiles |
| ★★★ | indicates a score at or between the 50th and 74th percentiles |
| ★★ | indicates a score at or between the 25th and 49th percentiles |
| ★ | indicates a score below the 25th percentile |

Additionally, HSAG performed a trend analysis of the adult Medicaid and CHIP results. The CHIP 2018 CAHPS scores were compared to their corresponding 2017 CAHPS scores to determine whether there were statistically significant differences. The adult Medicaid 2018 CAHPS scores were compared to their corresponding 2016 CAHPS scores to determine whether there were statistically significant differences.[A-6] Lastly, the adult Medicaid QI health plans' and the QI statewide aggregate's 2018 CAHPS scores were compared to the 2017 NCQA adult Medicaid national averages. 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/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 February to May 2018 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-7] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the Adult 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 Adult 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-6] HSAG did not survey the adult Medicaid population in 2017.

[A-7] A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for adult Medicaid: questions 3, 15, 24, 28, and 35. A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for CHIP: questions 3, 15, 27, 31, and 36.

# Provider Survey

## Objective

The objective of the provider survey was to provide feedback to the MQD and the health plans about providers' perceptions of the QI health plans.

## Technical Methods of Data Collection and Analysis

The method of data collection was through the administration of the 2018 Hawaii Provider Survey to a random sample of 1,500 providers: 200 KFHP providers (i.e., KFHP QI) and 1,300 non-KFHP providers (i.e., AlohaCare QI, HMSA QI, 'Ohana (WellCare) QI, and UnitedHealthcare Community Plan QI). Providers eligible for sampling included those who served the Hawaii Medicaid population, contracted with at least one of the QI health plans, and had the following credentials: doctor of medicine (MD), doctor of osteopathic medicine (DO), physician assistant (PA), psychologist, or advance practice registered nurse (APRN). The survey administration consisted of mailing sampled providers a survey questionnaire, cover letter, and business reply envelope. Providers were given two options by which they could complete the surveys: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope; or (2) complete the web-based survey by logging on to the survey website with a designated, provider-specific login. The survey was administered from September to November 2018. The survey administered to KFHP providers included 17 questions, and the survey administered to non-KFHP providers included 18 questions on a broad range of topics.

The 2016 and 2018 Hawaii Provider Survey results for participating QI health plans were presented on the following six domains of satisfaction:

- **General Positions**—presents providers' level of satisfaction with the reimbursement rate (pay schedule) or compensation, and providers' level of satisfaction with the timeliness of claims payments.
- **Providing Quality Care**—presents providers' level of satisfaction with the QI health plans' prior authorization process and formulary, in terms of having an impact on providers' ability to deliver quality care.
- **Non-Formulary**—presents providers' level of satisfaction with access to nonformulary drugs.
- **Service Coordinators**—presents providers' level of satisfaction with the helpfulness of service coordinators.
- **Specialists**—presents providers' level of satisfaction with the QI health plans' number of specialists; number of behavioral health specialists; and availability of mental health providers, including psychiatrists.
- **Substance Abuse**—presents providers' level of satisfaction with the QI health plans' access to substance abuse treatment for patients.

Response options to each question within these domains were classified into one of three response categories: satisfied, neutral, and dissatisfied; or positive impact, neutral impact, and negative impact. For each question, the proportion (i.e., percentage) of responses in each of the response categories was calculated.[A-8] Health plan survey responses were not limited to those providers who indicated they were currently accepting new patients for that health plan in Question 1 of the survey. For example, if a provider indicated that he or she was not currently accepting new patients for AlohaCare in Question 1, the response would be included in the results pertaining to AlohaCare if a response had been provided. Therefore, providers may have rated a health plan on a survey question even if they were not currently accepting new patients for that plan. Furthermore, if a provider was associated with more than one health plan, he or she may have answered a question for multiple health plans.

A Hierarchical Model for Latent Variables was used to determine if statistically significant differences in performance existed between the QI health plans' top-box rates and the QI Program aggregate, and between the 2018 and corresponding 2016 top-box rates. As is standard in most survey implementations, a top-box rate was defined by a positive or satisfied response.

Statistically significant differences between the QI health plans' top-box responses and the QI Program aggregate are noted with arrows. A QI health plan's top-box rate that was statistically significantly higher than the QI Program aggregate is noted with an upward (↑) arrow. A QI health plan's top-box rate that was statistically significantly lower than the QI Program aggregate is noted with a downward (↓) arrow. A QI health plan's top-box rate that was not statistically significantly different than the QI Program aggregate is not denoted with an arrow.

Statistically significant differences between the 2018 top-box rates and the corresponding 2016 top-box rates are noted with directional triangles. Rates that were statistically significantly higher in 2018 than in 2016 are noted with black upward (▲) triangles. Rates that were statistically significantly lower in 2018 than in 2016 are noted with black downward (▼) triangles. Rates in 2018 that were not statistically significantly different from rates in 2016 are not noted with triangles.

## *Description of Data Obtained*

The survey covered topics for primary care and specialty providers including the impact of plans' prior authorization procedures and formulary on the providers' ability to provide quality care. Additional survey questions elicited information about reimbursement satisfaction, adequacy of access to nonformulary drugs, service coordinators, adequacy of access to specialty providers and behavioral health specialists, availability of mental health providers, and access to substance abuse treatment. The response rate was the total number of completed surveys divided by all eligible providers within the sample. Eligible providers included the entire sample minus ineligible providers, which included any providers who could not be surveyed due to incorrect or incomplete contact information or who had no current contract with any of the QI health plans.

[A-8] For this report, only the top-box rates are displayed. For more detailed results on the other response categories, please see the 2018 Hawaii Provider Survey full report.

Following the administration of the provider survey, HSAG provided the MQD with an aggregate report of plan-specific findings. The plan-specific results are summarized in Section 3, and a statewide comparison of all plans' results are summarized in Section 4 of this report.