State of Hawaii

Department of Human Services

Med-QUEST Division

2019 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

January 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Overview

The 2019 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]

[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: July 16, 2019.

This report provides:

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

Scope of EQR Activities

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

- *Review of compliance with federal and state-specified operational standards*. HSAG evaluated the health plans' compliance with State and federal requirements for organizational and structural performance. The MQD contracts with the EQRO to conduct a review of one-half of the full set of standards in Year 1 and Year 2 to complete the cycle within a three-year period. HSAG conducted on-site compliance reviews in March 2019. The health plans submitted documentation that was in effect during 2018. HSAG provided detailed, final audit reports to the health plans and the MQD in June/July 2019.
- *Validation of performance improvement projects (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. In 2019, the health plans concluded the rapid-cycle PIP topics started in 2017 and subsequently started new MQD-selected PIP topics.
- *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 2019 through July 2019. The final PM validation results generally reflect the measurement period of January 1, 2018, through December 31, 2018. HSAG provided final audit reports to the health plans and the MQD in July 2019.

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

- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys*.[1-5] The MQD conducted CAHPS surveys of the child QI health plans and Children's Health Insurance Program (CHIP) populations to learn more about members' experiences with care. The standardized survey instrument administered to parents/caretakers of child Medicaid members of the QI health plans and 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 chronic conditions [CCC] measurement set). All sampled members completed the surveys from February to May 2019. HSAG aggregated and produced a final report in September 2019.

Overall Summary of Health Plan Performance

Compliance Monitoring Review

Calendar year (CY) 2019 began a new three-year cycle of compliance reviews for the QI health plans and the CCS program.

For the 2019 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs, using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the CFR for six areas of review, or standards. Both a pre-on-site desk review and an on-site review with interview sessions, system and process demonstrations, and record reviews were conducted.

The second compliance review activity in 2019 involved HSAG's and the MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to findings from the 2019 compliance review, which were all addressed by the end of 2019 or early 2020.[1-6]

Findings, Conclusions, and Recommendations

Table 1-1 summarizes the results from the 2019 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-6] KFHP QI completed all outstanding CAP items from the 2017 compliance monitoring reviews in March 2019.

Table 1-1—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
Coverage and Authorization of Services	78%	88%	75%	72%	88%	84%	**81%**
Access and Availability	100%	100%	88%	88%	100%	85%	**94%**
Coordination and Continuity of Care	90%	90%	80%	100%	100%	67%	**88%**
Member Rights and Protections	89%	56%	56%	89%	89%	89%	**78%**
Member Information	82%	64%	59%	77%	73%	76%	**72%**
Member Grievance System	56%	74%	70%	67%	78%	70%	**69%**
Totals	**78%**	**79%**	**72%**	**78%**	**85%**	**78%**	**78%**

***Totals*:** The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.

In general, health plan performance suggested that all health plans had yet to fully implement the revised federal healthcare regulations released in May 2016, and effective July 2017 for Medicaid managed care programs. While the health plans had systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii, their policies, processes, and systems were not updated to include several significant changes as outlined in the revised managed care regulations. The QI health plans scored highest in the *Access and Availability* and *Coordination and Continuity of Care* standards. The *Member Grievance System* and *Member Information* standards were identified as having the greatest opportunity for improvement with statewide compliance scores of 69 percent and 72 percent, respectively. Overall, all five QI health plans and the CCS program needed to implement several policy and process changes to bring them into compliance with both federal managed care regulations and State contract provisions.

Individual health plan performance revealed the following:

- AlohaCare QI's performance across all standards was average, meeting or exceeding the statewide compliance score for four of the six standards.
  - AlohaCare QI had a total compliance score of 78 percent with one of the six standards scoring 100 percent: *Access and Availability.* AlohaCare QI also achieved a high score (90 percent) in the *Coordination and Continuity of Care* standard, with only one element scoring a *Not Met*.
  - AlohaCare QI scored 56 percent in the *Member Grievance System* standard, well below all other health plans.
  - AlohaCare QI was required to develop a corrective action plan (CAP) to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.
- HMSA QI's performance across all standards was average, meeting or exceeding the statewide compliance score for four of the six standards.

  - HMSA QI had a total compliance score of 79 percent with one of the six standards scoring 100 percent: *Access and Availability.* HMSA QI also achieved a high score (90 percent) in the *Coordination and Continuity of Care* standard, with only one element scoring a *Not Met*.
  - HMSA QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor HMSA's QI CAP activities until the health plan is found to be in full compliance.
- KFHP QI's performance across all standards was below all other health plans, with five of the six standards scoring below the statewide score.
  - KFHP QI had the lowest performance with a total compliance score of 72 percent and no standards scoring 100 percent.
  - KFHP QI's total compliance score was driven by low compliance noted in all standards.
  - KFHP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor KFHP's QI CAP activities until the health plan is found to be in full compliance.
- 'Ohana QI's performance across all standards was average, meeting or exceeding the statewide compliance score for three of the six standards.
  - 'Ohana QI had a total compliance score of 78 percent with one of the six standards scoring 100 percent: *Coordination and Continuity of Care.* 'Ohana QI also achieved a high score (89 percent) in the *Member Rights and Protections* standard, with only one element scoring a *Not Met*.
  - 'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana QI's CAP activities until the health plan is found to be in full compliance.
- UHC CP QI's performance across all standards was above average, meeting or exceeding the statewide compliance score for all standards.
  - UHC CP QI had the highest performance with a total compliance score of 85 percent with two of the six standards scoring 100 percent: *Access and Availability* and *Coordination and Continuity of Care*. UHC CP QI also achieved high scores in the *Coverage and Authorization of Services* standard (88 percent) and the *Member Rights and Protections* standard.
  - UHC CP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor UHC CP's CAP activities until the health plan is found to be in full compliance.
- 'Ohana CCS' performance across all standards was average, meeting or exceeding the statewide compliance score for four of the six standards.
  - 'Ohana CCS had a total compliance score of 78 percent and did not score 100 percent in any of the standards.
  - 'Ohana CCS scored 67 percent in the *Coordination and Continuity of Care* standard, well below all other health plans.
  - 'Ohana CCS was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

With the completion of compliance monitoring reviews and a corrective action process, the health plans and CCS have demonstrated their structural and operational compliance and ability to support the provision of quality, timely, and accessible services. CY 2020 will be the second year in the three-year cycle for compliance reviews. The reviews will target the remaining eight standards: Provider Selection, Credentialing, Subcontractual Relationships and Delegation, Enrollment and Disenrollment, Practice Guidelines, Program Integrity, Quality Assessment and Performance Improvement, and Health Information Systems.

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 *HEDIS 2019 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.*[1-7] 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.[1-8] 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 2018 (January 1, 2018, through December 31, 2018), and the audit activities were conducted concurrently with HEDIS 2019 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 31 measures, yielding a total of 113 measure indicators, for the QI population. 'Ohana CCS was required to report on 10 measures, yielding a total of 53 measure indicators, for the CCS program. The measures were organized into the following six categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services.

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

[1-7] National Committee for Quality Assurance. *HEDIS 2019 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.* Washington, DC: NCQA; 2018.

[1-8] 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: Dec 4, 2019.

Findings, Conclusions, and Recommendations

NCQA HEDIS Compliance Audit

HSAG evaluated each QI health plan's compliance with NCQA information system (IS) standards during the 2019 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 UHC CP QI (IS 5.0: *Partially Compliant*). Overall, the health plans followed the NCQA HEDIS 2019 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of *Reportable*.

Performance Measure Results

HSAG analyzed the HEDIS 2019 (CY 2018) performance measure results for each health plan, and where applicable, HSAG compared the results to NCQA's Quality Compass® national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018 (referred to throughout this report as percentiles).[1-9] For two measure indicators where a lower rate indicates better performance (i.e., *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits* and *Ambulatory Care—Emergency Department [ED] Visits—Total)*, HSAG reversed the order of the benchmarks for performance level evaluation to be consistently applied.[1-10]

Additionally, HSAG analyzed the results for three performance measures developed by the MQD (i.e., *Behavioral Health Assessment*, *Follow-Up With a Primary Care Practitioner [PCP] After Hospitalization for Mental Illness*, and *ED Visits for Ambulatory Care-Sensitive Conditions*). Of note, these measures do not have applicable benchmarks for comparison.

In the following figures, "N" indicates, by health plan, the total number of performance measure indicators that were compared to the benchmarks for QI and CCS. Rates for which comparisons to benchmarks were not appropriate or rates that were not reportable (e.g., small denominator, biased rate) were not included in the summary results.

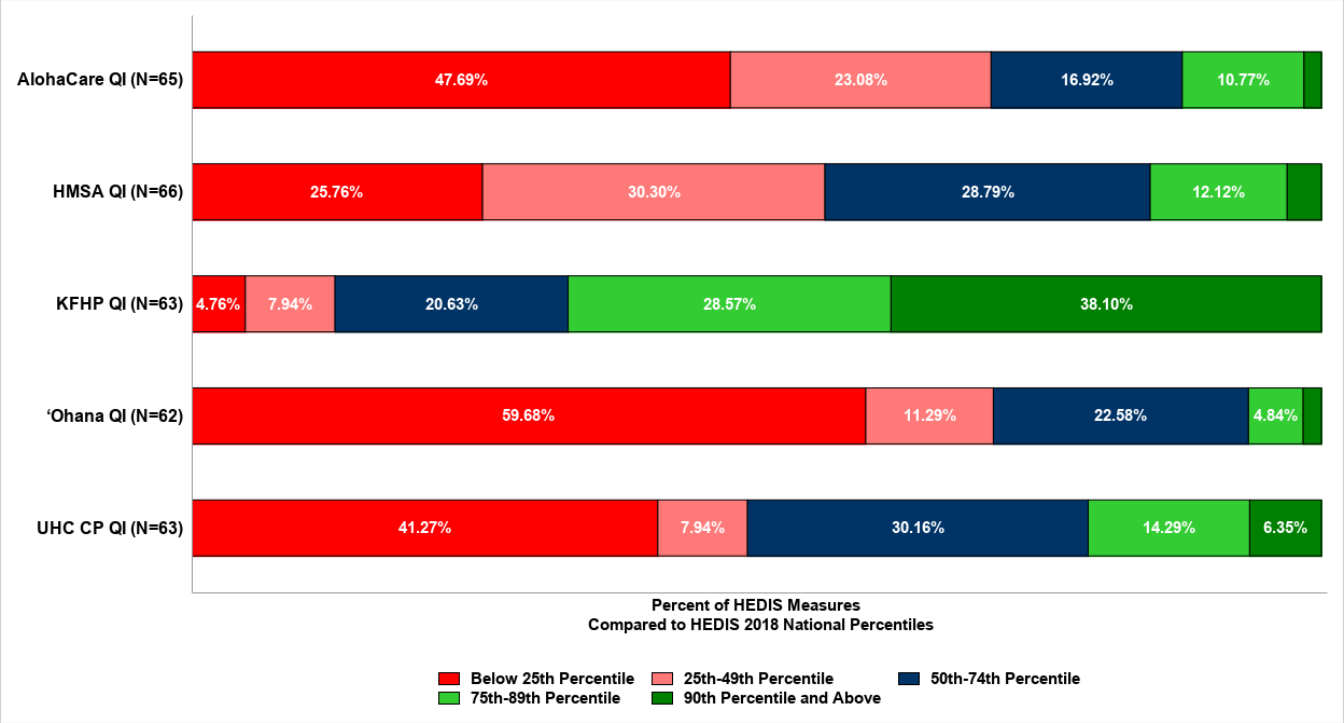
Figure 1-1 displays the QI health plans' HEDIS 2019 performance compared to benchmarks, where applicable. HSAG analyzed results from 31 performance measures for HEDIS 2019 (a total of 96 indicator rates), of which 67 indicators were comparable to benchmarks.[1-11] Of note, none of the health plans had reportable rates for all 67 indicators, due to an audit designation of *NA* (i.e., *Small Denominator*).

[1-9] Quality Compass® is a registered trademark of the NCQA.

[1-10] For example, because the value associated with the 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.

[1-11] 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



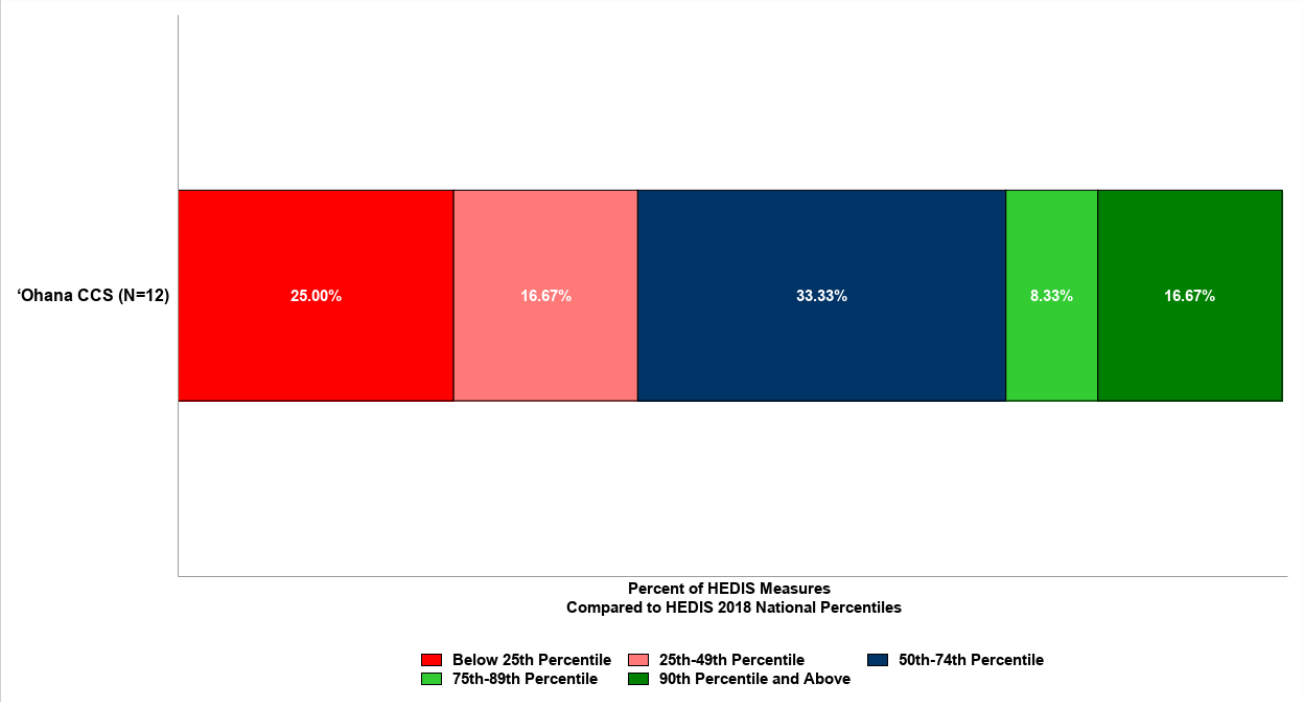
As presented in Figure 1-1, KFHP QI was the highest-performing plan for HEDIS 2019 with 55 of 63 (87.3 percent) measure rates ranking at or above the 50th percentile, including 24 of the rates (38.1 percent) exceeding the 90th percentile. UHC CP QI was the second-highest-performing health plan with 32 of 63 (50.8 percent) measure rates ranking at or above the 50th percentile, including 13 of the rates (20.6 percent) ranking above the 75th percentile. For HMSA QI, 29 of 66 (43.9 percent) measure rates ranked at or above the 50th percentile, with 10 of the rates (15.2 percent) ranking at or above the 75th percentile.

Conversely, AlohaCare QI and 'Ohana QI fell below the 50th percentile for 46 of 65 (70.8 percent) and 44 of 62 (71.0 percent) measure rates, respectively, indicating opportunities for improvement. Further, 37 (59.7 percent) of 'Ohana QI's measure rates and 31 (47.7 percent) of AlohaCare QI's measure rates fell below the 25th percentile. Of note, AlohaCare QI and 'Ohana QI each had one measure rate that exceeded the 90th percentile.

Additionally, 14 of 15 measures with MQD Quality Strategy targets were comparable to benchmarks for HEDIS 2019. KFHP QI demonstrated positive performance, meeting 12 of 14 (85.7 percent) targets. Conversely, the remaining four QI health plans demonstrated opportunities to improve care overall by meeting fewer than six of the targets: AlohaCare QI (no targets met), HMSA QI (two targets met), 'Ohana QI (two targets met), and UHC CP QI (five targets met).

Figure 1-2 displays the 'Ohana CCS' HEDIS 2019 (CY 2018) performance on those measure indicators that could be compared to benchmarks. Of note, 'Ohana CCS had two measure rates with denominators less than 30 for which valid rates could not be reported (i.e., *Small Denominator*).

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



'Ohana CCS demonstrated overall strength, with seven of 12 (58.3 percent) measure rates ranking at or above the 50th percentile. Conversely, three of 12 (25.0 percent) measure rates fell below the 25th percentile, indicating opportunities for improvement. 'Ohana CCS demonstrated positive performance, meeting both targets (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*) in HEDIS 2019.

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 rapid-cycle PIPs based on plan-specific data that demonstrated a need for improvement.

HSAG's rapid-cycle 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.

- **Module 1—PIP Initiation:** MCOs document the PIP framework that includes topic rationale, supporting data, a PIP team, aims (Global and SMART), and a key driver diagram.
- **Module 2—SMART Aim Data Collection:** MCOs define the SMART Aim measure and describe the data collection methodology.
- **Module 3—Intervention Determination:** There is increased focus on the quality improvement activities reasonably thought to impact the SMART Aim. MCOs identify interventions using process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking.
- **Module 4—Plan-Do-Study-Act (PDSA):** MCOs test and evaluate interventions identified in Module 3 using PDSA cycles.
- **Module 5—PIP Conclusions:** MCOs summarize key findings, outcomes, lessons learned, and a plan to sustain improvement achieved.

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 was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the health plan accurately summarized the key findings.

Confidence = The PIP was methodologically sound, the SMART Aim was achieved, and the health plan 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.

Reported PIP results were not credible = The PIP methodology was not executed as approved.

Findings, Conclusions, and Recommendations

In 2019, HSAG validated the Module 4 and Module 5 submissions for two PIPs for each of the QI and CCS health plans, for a total of 12 PIPs. With the submission and validation of Module 4 and Module 5, the projects concluded and HSAG provided a confidence level for each PIP. Subsequently in August 2019, the QI and CCS health plans submitted Module 1 and Module 2 for the new MQD-selected PIP topics. At the time of this report, the health plans were in the Module 1 and Module 2 resubmission process to address HSAG's validation feedback prior to progressing to Module 3.

Based on the Module 4 and Module 5 validations, HSAG recommends that health plans:

- Follow the approved methodologies for the PIPs and report results accurately and completely, according to the approved methodologies.
- Select active, innovative interventions to test for the rapid-cycle PIPs.

- Start testing interventions for the PIP in a timely manner to impact the SMART Aim measure results by the SMART Aim end date.
- Ensure that interventions tested for the rapid-cycle PIP reach enough members to impact the SMART Aim, and that data can provide a clear linkage between improvement in the SMART Aim measure results and change(s) tested for the PIP.
- Provide complete and accurate documentation of PIP results, including the monthly numerators and denominators for the SMART Aim measures and numerator and denominator data for the intervention effectiveness measures.
- Apply lessons learned and knowledge gained to future PIPs and quality improvement activities.

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

The CAHPS health plan surveys are standardized survey instruments which measure patients' experience with their healthcare. For 2019, HSAG administered the CAHPS 5.0H Child Medicaid Health Plan Survey to parents and caretakers of child Medicaid members of the QI health plans and to a statewide sample of CHIP members, who met age and enrollment criteria. All members of sampled child Medicaid and CHIP members completed the surveys from February to May 2019 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 experience 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-box 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-box responses was calculated in order to determine the top-box scores.

[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 Child Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required in order to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.

Findings, Conclusions, and Recommendations

Table 1-2 presents the 2019 percentage of top-box responses for the QI Program aggregate compared to the 2018 NCQA child Medicaid national averages and the corresponding 2017 top-box scores.[1-13,1-14] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the QI Program aggregate's top-box scores compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-15]

Table 1-2—QI Program Child CAHPS Results

	2017 Scores	2019 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	69.1%	70.4%	★★
Rating of All Health Care	65.0%	66.9%	★★
Rating of Personal Doctor	74.1%	75.6%	★★
Rating of Specialist Seen Most Often	72.9%	73.0%	★★
Composite Measures			
Getting Needed Care	82.8%	81.2%	★
Getting Care Quickly	86.4%	85.5%	★
How Well Doctors Communicate	94.4%	94.2%	★★★
Customer Service	86.9%	85.0%	★
Shared Decision Making	82.7%	80.3%	★★★
Individual Item Measures			
Coordination of Care	83.8%	83.8%	★★★
Health Promotion and Education	75.8%	77.9%	★★★★★

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child Medicaid national averages.
▲ Indicates the 2019 score is statistically significantly higher than the 2017 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
+ 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

Comparison of the 2019 QI Program's scores to the 2018 NCQA child Medicaid national averages revealed the following summary results:

[1-13] 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.
[1-14] The adult population was last surveyed in 2018; therefore, the 2019 child CAHPS scores are compared to the corresponding 2017 scores.
[1-15] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

- The QI Program's scores were at or above the national averages on four measures: *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- The QI Program's scores were below the national averages on seven 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*, and *Customer Service*.

The trend analysis revealed that the 2019 QI Program aggregate scores were not statistically significantly higher or lower than the 2017 scores on any of the measures.

Comparison of the QI Program aggregate to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The QI Program scored at or above the 90th percentile on one measure, *Health Promotion and Education*.
- The QI Program scored below the 25th percentile on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Table 1-3 presents the 2019 percentage of top-box responses for the Hawaii CHIP population compared to the 2018 NCQA child Medicaid national averages and the corresponding 2018 top-box scores. 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 experience ratings (i.e., star ratings) resulting from the top-box scores compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-16]

Table 1-3—2019 CHIP CAHPS Results

	2018 Scores	2019 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	72.4%	71.4%	★★★
Rating of All Health Care	67.9%	66.4%	★
Rating of Personal Doctor	73.2%	77.1%	★★★
Rating of Specialist Seen Most Often	75.3%+	67.9%+	★
Composite Measures			
Getting Needed Care	85.9%	76.0% ▼	★
Getting Care Quickly	85.0%	85.3%	★
How Well Doctors Communicate	96.4%	95.8%	★★★★
Customer Service	85.9%+	84.7%+	★

[1-16] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

	2018 Scores	2019 Scores	Star Ratings
Shared Decision Making	79.1%	75.9%+	★★
Individual Item Measures			
Coordination of Care	84.2%	91.2%	★★★★★
Health Promotion and Education	78.2%	75.3%	★★★★

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child Medicaid national averages.
▲ Indicates the 2019 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2018 score.
+ 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

An evaluation of the CHIP population's 2019 scores to the 2018 NCQA child Medicaid national averages revealed the following summary results:

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

The trend analysis of the CHIP population's scores revealed the following summary result:

- The CHIP population's 2019 score was statistically significantly lower than the 2018 score on one measure, *Getting Needed Care*.

Comparison of the CHIP population's scores to the NCQA's 2018 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The CHIP population scored at or above the 90th percentile on one measure, *Coordination of Care*.
- The CHIP population scored below the 25th percentile on five measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

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: July 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, 2019, through December 31, 2019, 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 340,000[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 2019, as cited in *Hawaii Medicaid Enrollment for the Year 2019,* available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/enrollment-reports/2019_New_Enrollment_Report_Jan-Apr.pdf Accessed on: July 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: July 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 60,000 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 160,000 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 over 38,000 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 48,000Medicaid 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 July 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.

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 2019 EQR activities and conclusions as to the strengths and weaknesses of each health plan about the quality of, timeliness of, and access to care furnished by the Hawaii Medicaid health plans serving the QUEST Integration members. Additionally, recommendations are offered to each health plan to facilitate continued quality improvement in the Medicaid program.

Methodology

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

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

  Quality, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired outcomes of its enrollees through:
  - Its structural and operational characteristics.
  - The provision of services that are consistent with current professional, evidence-based knowledge.
  - Interventions for performance improvement.[3-1]
- **Access**—CMS defines "access" in the final rule at 42 CFR §438.230 as follows:

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

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction,* September 2012.
[3-2] Ibid.

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

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

Appendix A of this report contains detailed information about the methodologies used to conduct each of the 2019 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 2019 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-1 presents the standards and compliance scores for AlohaCare QI.

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

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	25	7	78%
II	Access and Availability	16	16	0	100%
III	Coordination and Continuity of Care	10	9	1	90%
IV	Member Rights and Protections	9	8	1	89%
V	Member Information	22	18	4	82%

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

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
VI	Member Grievance System	27	15	12	56%
	Totals	**116**	**91**	**25**	**78%**
Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.					

Strengths

AlohaCare QI was found to be 100 percent compliant with the *Access and Availability* standard. The health plan had policies and procedures in place to ensure that all covered services were available and accessible to members in a timely manner and met the standards developed by the State for network adequacy. GeoAccess reports showed that AlohaCare QI had an adequate network of hospitals, primary care providers (PCPs), and specialists to meet State standards. AlohaCare QI had an ongoing, integrated approach to monitoring access and availability that included monthly, quarterly, and annual reviews of network data.

The health plan also scored high with the Coordination and Continuity of Care standard with 90 percent compliance, with only one element scoring a *Not Met.* AlohaCare QI demonstrated through its policies, procedures, and reports that it had systems and processes in place to identify, assess, plan, implement, coordinate, and monitor care coordination through the health plan's care coordination/case management program. All members were evaluated proactively to ensure effective identification and assessment of members' needs for services that were specifically targeted to AlohaCare QI members identified with special healthcare needs (SHCN), those receiving long-term services and supports (LTSS), members at the high-risk care management level, and members with Medicare and Medicaid.

AlohaCare QI was found to be 89 percent compliant with the Member Rights and Protections standard, with only one element scoring a *Not Met.* AlohaCare QI had policies, procedures, and written member and provider information regarding member rights. The health plan ensured that providers took member rights into account when furnishing services by providing in-service trainings, conducting provider visits, and disseminating provider manuals and newsletters containing member rights information. AlohaCare QI ensured that employees took member rights into account by providing new employee and annual member rights and compliance trainings, member handbook training, and grievance and appeals training. AlohaCare QI monitored grievances and appeals through quarterly reports to ensure that member rights were protected.

Areas for Improvement

AlohaCare QI was found to be 82 percent compliant with the Member Information standard, with four elements scoring a *Not Met.* In general, AlohaCare QI had member information, customer service staff members, and service coordinators available to help members understand the requirements and benefits of the plan. The corrective actions required by AlohaCare QI were related to member handbook updates

to ensure correct information was provided to members and implementing processes to evaluate the health plan's website and member documents to ensure information was readily accessible to all members.

AlohaCare QI was found to be compliant with 78 percent of the Coverage and Authorization of Services standard, with seven elements scoring a *Not Met.* Overall, AlohaCare QI exhibited well-documented policies and procedures that clearly outlined contract requirements and processes. However, in some areas, additional language was needed to better align the health plan's policies with the CFRs. In addition, review of authorization and denial decisions identified the need for AlohaCare QI to revise processes and member notification letter templates to ensure timeliness of decisions and accuracy of information provided to members.

AlohaCare QI was found to be compliant with 56 percent of the Member Grievance System standard, with 12 elements scoring a *Not Met.* While AlohaCare QI had comprehensive policies and procedures for processing grievances and appeals, many of the processes and time frames used by the health plan were not in alignment with the current federal regulations and State contracts. The corrective actions required by AlohaCare QI were related to updating policies, procedures, member notification letter templates, and provider information to be in compliance with federal and State regulations.

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. 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 16 standard supplemental data sources for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2019 measure reporting. All convenience samples passed HSAG's review.

The auditors did not have any recommendations for AlohaCare QI.

All QI measures which AlohaCare QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted. For AlohaCare QI reporting, the *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, Follow-Up After Emergency Department Visit for Mental Illness*, *Follow-Up After Hospitalization for Mental Illness,* and *Follow-Up Care for Children Prescribed ADHD Medication.* 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—Counseling for Nutrition (Total)*
- Group C: Laboratory—*Comprehensive Diabetes Care-HbA1c Poor Control (>9.0%)*
- Group D: Immunization & Other Screenings—*Comprehensive Diabetes Care-Eye Exam (Retinal) Performed*
- Group F: Exclusions—All Medical Record Exclusions

Access to Care Performance Measure Results

AlohaCare QI's Access to Care performance measure results are shown in Table 3-2. None of the rates in this domain demonstrated a relative improvement or decline of more than 10 percent in HEDIS 2019. All 10 measure rates fell below the 50th percentile, including eight measure rates falling below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2019.

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

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adults' Access to Preventive/Ambulatory Health Services[1]				
20–44 Years	60.30%	60.80%	0.83%	★
45–64 Years	72.80%	72.99%	0.26%	★
65 Years and Older	79.98%	80.58%	0.75%	★
Total	65.66%	66.52%	1.31%	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	95.88%	95.31%	-0.59%	★★
25 Months–6 Years	83.78%	84.22%	0.53%	★
7–11 Years	85.81%	86.74%	1.08%	★
12–19 Years	83.74%	85.32%	1.89%	★
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	38.77%	36.71%	-5.31%	★
Engagement of AOD Treatment—Total	10.54%	9.93%	-5.79%	★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.*

2019 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 2019. Four rates in this domain demonstrated a relative improvement of more than 10 percent. Additionally, five measure rates ranked at or above the 50th percentile, with three of these rates ranking at or above the 75th percentile. Conversely, 13 measure rates fell below the 25th percentile. One measure in this domain had an MQD Quality Strategy target for HEDIS 2019 (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 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.64%	50.61%	1.95%	★★
Childhood Immunization Status[1]				
Combination 3	59.61%	59.61%	0.00%	★
DTaP	64.72%	66.18%	2.26%	★
Hepatitis B	80.54%	78.59%	-2.42%	★
HiB	78.83%	79.56%	0.93%	★
IPV	80.29%	81.75%	1.82%	★
MMR	80.54%	78.59%	-2.42%	★
Pneumococcal Conjugate	64.23%	66.67%	3.80%	★
VZV	78.83%	77.62%	-1.53%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tetanus, Diphtheria Toxoids and Acellular Pertussis [Tdap])	51.82%	56.45%	8.93%	★
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	22.38%	25.55%	14.16%	★
HPV	24.33%	28.47%	17.02%	★★
Meningococcal	55.47%	59.12%	6.58%	★
Tdap	56.69%	62.53%	10.30%	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	0.97%	0.73%	-24.74%	★★★★
Six or More Well-Child Visits	72.75%	73.48%	1.00%	★★★★
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%	66.18%	-0.36%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	84.43%	85.89%	1.73%	★★★★

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Counseling for Nutrition—Total	73.48%	71.05%	-3.31%	★★★
Counseling for Physical Activity—Total	71.05%	65.94%	-7.19%	★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
2019 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. Three rates in this domain demonstrated a relative improvement of more than 10 percent for HEDIS 2019. All seven measure rates fell below the 50th percentile, with five of these rates falling below the 25th percentile. Three measures[3-6] in this domain had an MQD Quality Strategy target for HEDIS 2019. 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 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Breast Cancer Screening[1]				
Breast Cancer Screening	47.48%	50.39%	6.13%	★
Cervical Cancer Screening				
Cervical Cancer Screening	48.42%	54.74%	13.05%	★★
Chlamydia Screening in Women				
16–20 Years	37.01%	37.44%	1.16%	★
21–24 Years	41.00%	45.24%	10.34%	★
Total	38.94%	41.04%	5.39%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	64.23%	78.83%	22.73%	★★
Postpartum Care	51.82%	54.50%	5.17%	★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.

[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*.

2019 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 2019. Three rates in this domain reported a relative improvement of more than 10 percent. Additionally, three measures ranked at or above the 50th percentile. The remaining eight measure rates that could be compared to national benchmarks fell below the 50th percentile, with one of these rates falling below the 25th percentile. Additionally, the *Medication Management for People With Asthma—Medication Compliance 75%—Total* measure rate demonstrated a relative decline of more than 10 percent in HEDIS 2019. Seven measures[3-7] within this domain were associated with an MQD Quality Strategy target for HEDIS 2019, and AlohaCare QI did not meet the target for any of these measures.

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

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Annual Monitoring for Patients on Persistent Medications				
Angiotensin Converting Enzyme (ACE) Inhibitors or Angiotensin Receptor Blockers (ARBs)	86.44%	86.21%	-0.27%	★★
Diuretics	87.26%	87.69%	0.49%	★★
Total	86.70%	86.69%	-0.01%	★★
Comprehensive Diabetes Care[1]				
Hemoglobin A1c (HbA1c) Testing	79.32%	86.62%	9.20%	★★
*HbA1c Poor Control (>9.0%)**	49.39%	42.34%	-14.27%	★★
HbA1c Control (<8.0%)	40.15%	47.20%	17.56%	★★
Eye Exam (Retinal) Performed	54.50%	60.83%	11.61%	★★★
Medical Attention for Nephropathy	87.35%	86.62%	-0.84%	★
Blood Pressure Control (<140/90 mm Hg)	55.23%	60.58%	9.69%	★★
Controlling High Blood Pressure[2]				
Controlling High Blood Pressure	—	53.77%	—	NC

[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). Due to technical specification changes for HEDIS 2019, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Controlling High Blood Pressure* measure.

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Medication Management for People With Asthma[1]				
Medication Compliance 50%—Total	63.77%	60.70%	-4.81%	★★★
Medication Compliance 75%—Total	42.51%	36.53%	-14.07%	★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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

AlohaCare QI's Behavioral Health performance measure results are shown in Table 3-6. Eight rates reported a relative decline of more than 10 percent in HEDIS 2019. Additionally, four measure rates fell below the 25th percentile. Conversely, six of the measure rates that could be compared to benchmarks ranked at or above the 50th percentile, and two measure rates demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Two measures[3-8] in this domain had an MQD Quality Strategy target for HEDIS 2019, and AlohaCare QI did not reach the established targets, the 75th percentile.

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

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	55.16%	51.00%	-7.54%	★★
Effective Continuation Phase Treatment	37.67%	33.55%	-10.94%	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia[1]				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	—	NC

[3-8] Within this domain, there were two MQD Quality Strategy targets: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total.*

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[1]				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	71.46%	73.03%	2.20%	★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7 Day Follow-Up—13–17 Years	10.53%	11.43%	8.55%	★★★★
7 Day Follow-Up—18+ Years	15.92%	12.10%	-23.99%	★★★
7 Day Follow-Up—Total	15.58%	12.05%	-22.66%	★★★
30 Day Follow-Up—13–17 Years	10.53%	20.00%	89.93%	★★★★
30 Day Follow-Up—18+ Years	23.26%	19.76%	-15.05%	★★★
30 Day Follow-Up—Total	22.45%	19.77%	-11.94%	★★★
Follow-Up After ED Visit for Mental Illness[2]				
7-Day Follow-Up—Total	—	26.03%	—	NC
30-Day Follow-Up—Total	—	40.98%	—	NC
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—Total	20.83%	18.69%	-10.27%	★
30-Day Follow-Up—Total	36.74%	41.52%	13.01%	★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	36.90%	29.73%	-19.43%	★
Continuation and Maintenance Phase	NA	NA	—	NC
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness				
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	32.24%	27.36%	-15.13%	NC

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 for HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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. Excluding *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*, *ED Visits for Ambulatory Care Sensitive Conditions*, 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 *Plan All-Cause Readmissions*, one measure rate demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, all four *Plan All-Cause Readmissions* measure rates ranked at or above the 50th percentile, with one of these rates exceeding the 90th percentile; however, two of the measure rates demonstrated a relative increase of more than 10 percent, indicating worse performance. Neither of the *ED Visits for Ambulatory Care Sensitive Conditions* measure rates demonstrated a relative improvement or decrease of more than 10 percent in HEDIS 2019. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure ranked at or above the 75th percentile but failed to meet the MQD Quality Strategy target for HEDIS 2019, the 90th percentile.

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

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	49.15	47.78	-2.79%	★★★★
Outpatient Visits—Total[1]	280.91	285.85	1.76%	NC
ED Visits for Ambulatory Care Sensitive Conditions*				
PCP Treatable ED Visits	12.22%	12.84%	5.09%	NC
Preventable/Avoidable ED Visits	69.99%	68.73%	-1.80%	NC
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	48.88%	48.74%	-0.29%	NC
20–44 Years Subtotal Percentage—Total	31.57%	30.72%	-2.69%	NC
45–64 Years Subtotal Percentage—Total	16.01%	16.18%	1.06%	NC
65+ Years Subtotal Percentage—Total	3.55%	4.36%	22.82%	NC
Inpatient Utilization—General Hospital/Acute Care—Total[1]				
Maternity—Average Length of Stay—Total	2.58	2.67	3.49%	NC
Maternity—Days per 1,000 Member Months—Total	6.99	7.21	3.15%	NC
Maternity—Discharges per 1,000 Member Months—Total	2.72	2.70	-0.74%	NC
Medicine—Average Length of Stay—Total	5.33	5.26	-1.31%	NC
Medicine—Days per 1,000 Member Months—Total	15.89	16.00	0.69%	NC
Medicine—Discharges per 1,000 Member Months—Total	2.98	3.04	2.01%	NC

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Surgery—Average Length of Stay—Total	9.83	10.44	6.21%	NC
Surgery—Days per 1,000 Member Months—Total	14.39	17.76	23.42%	NC
Surgery—Discharges per 1,000 Member Months—Total	1.46	1.70	16.44%	NC
Total Inpatient—Average Length of Stay—Total	5.54	5.85	5.60%	NC
Total Inpatient—Days per 1,000 Member Months—Total	35.21	38.81	10.22%	NC
Total Inpatient—Discharges per 1,000 Member Months—Total	6.36	6.63	4.25%	NC
Mental Health Utilization[2]				
Any Service—Total	—	7.66%	—	NC
Inpatient—Total	—	0.52%	—	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.08%	—	NC
Outpatient—Total	—	7.37%	—	NC
*ED—Total**	—	0.12%	—	NC
Telehealth—Total	—	0.07%	—	NC
Plan All-Cause Readmissions[1]*				
*Index Total Stays—Observed Readmissions—Ages 18–44**	14.58%	10.23%	-29.84%	★★★★★
*Index Total Stays—Observed Readmissions—Ages 45–54**	9.77%	15.74%	61.11%	★★★
*Index Total Stays—Observed Readmissions—Ages 55–64**	11.28%	13.51%	19.77%	★★★
*Index Total Stays—Observed Readmissions—Total**	12.36%	12.71%	2.83%	★★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 65 measure rates comparable to benchmarks, 19 measure rates (29.2 percent) ranked at or above the 50th percentile, with eight of these rates (12.3 percent) ranking above the 75th percentile, indicating positive performance regarding well-child visits for infants; weight assessments for children and adolescents; appropriate follow-up for young members with AOD abuse or dependence; and low ED utilization and readmissions.

Conversely, 46 of AlohaCare QI's measure rates comparable to benchmarks (70.8 percent) fell below the 50th percentile, with 31 of these rates (47.7 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains of care. Additionally, AlohaCare QI did not meet any of the MQD Quality Strategy targets for HEDIS 2019. HSAG recommends that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the 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*
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
- 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)*, *Combination 2 (Meningococcal, Tdap, HPV)*, *Meningococcal*, and *Tdap*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Breast Cancer Screening*
  - *Chlamydia Screening in Women—16–20 Years*, *21–24 Years*, and *Total*
  - *Prenatal and Postpartum Care—Postpartum Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- Behavioral Health
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Follow-Up After Hospitalization Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

Validation of Performance Improvement Projects

Findings

Getting Needed Care PIP

AlohaCare QI's focus for this PIP was to increase the mean score of the third question of the member survey as it related to the ease of access to ophthalmology services. Details of AlohaCare QI's intervention for the PIP are presented in Table 3-8 and in the narrative below.

Table 3-8—Intervention Testing for *Getting Needed Care* PIP

Intervention	Key Driver	Failure Mode	Conclusion
Reminder calls to targeted members two to three business days prior to the scheduled ophthalmologist visit	Geographical remoteness, lack of transport/accommodation /finances	Members not reminded of the final upcoming travel accommodation	The health plan chose to *adapt* the intervention.

The health plan tested reminder calls to members with travel arrangements for their ophthalmology appointments. The calls were targeted to members living in remote areas of Hawaii, where access to specialty care is a known barrier.

The health plan concluded:

- The intervention was effective and provided valuable information for adaption.
- Feedback from the survey can be provided to poor-performing providers and the health plan's staff with regard to member comments on customer service/travel arrangements.
- Retesting with lessons learned should result in higher scores.
- The intervention can be tested with other populations.

HSAG validated AlohaCare QI's *Getting Needed Care* PIP SMART Aim measure rates based on the results in Module 5. Table 3-9 provides the level of confidence HSAG assigned to the PIP.

Table 3-9—SMART Aim Results for *Getting Needed Care* PIP

SMART Aim	Average Score After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, AlohaCare will increase the mean score by 5% (from 4.11 to 4.32) using the third question of the member survey as it relates to the ease of access to ophthalmology services reported by	4.38	Yes	Yes	*High Confidence*

SMART Aim	Average Score After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
members paneled to the five (5) Community Health Centers (CHCs).				

The PIP was methodologically sound, and the SMART Aim goal was achieved. There appeared to be a clear linkage between improvement in the SMART Aim measure and the tested intervention. The final PIP assignment level was *High Confidence*.

Improving Timeliness of Prenatal and Postpartum Care PIP

AlohaCare QI's focus for this PIP was to increase the rate of members receiving timely prenatal care and postpartum care appointments. Details of AlohaCare QI's interventions for the PIP are presented in Table 3-10 and in the narrative below.

Table 3-10—Intervention Testing for *Improving Timeliness of Prenatal and Postpartum Care* PIP

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
1. Telephonic outreach to female members ages 16–50 years paneled at Kalihi Palama Health Center (KPHC) to schedule an appointment (if the member was not seen in the past 12 months)	Provider awareness of paneled pregnant patients	• Member does not schedule an appointment within the first trimester • Member did not receive education on preconception/prenatal health/family planning services	The health plan chose to *abandon* the intervention.
2. Identify and outreach telephonically newly enrolled pregnant members to assist with scheduling a prenatal appointment	Provider awareness of paneled pregnant patients	Member did not schedule an appointment on time, or after the first trimester	The health plan chose to *adapt* the intervention.
Postpartum Interventions	**Key Drivers**	**Failure Modes**	**Conclusion**
1. Incentivize a community health worker who has developed a relationship with the community and the member to outreach and ensure the	Community/provider bilingual support/resources	• Member does not understand the importance of routine follow-up postpartum care • Member attended the first postpartum visit	The health plan chose to *abandon* the intervention.

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
member receives postpartum care		but does not want to attend the second postpartum visit	
2. Individualized reminders by text, telephone, and mail	Community/provider bilingual support/resources	Member attended the first postpartum visit but does not want to attend the second postpartum visit	The health plan chose to *continue testing* the intervention.

For prenatal care, the health plan initiated two interventions simultaneously. Both interventions were tested from March 2018 through December 2018. The health plan concluded:

- Analysis indicated that the second intervention was effective.

For postpartum care, two interventions were initiated at different times. The health plan concluded:

- Neither intervention positively impacted the SMART Aim.
- The second intervention related to individualized reminders, tested from October 2018 through December 2018, showed some effectiveness; however, the effectiveness was not enough to impact the SMART Aim.

HSAG validated AlohaCare QI's *Improving Timeliness of Prenatal and Postpartum Care* PIP SMART Aim measure rates based on the results in Module 5. Table 3-11 provides the level of confidence HSAG assigned to the PIP.

Table 3-11—Status of the *Improving Timeliness of Prenatal and Postpartum Care* PIP

SMART Aim	Measure	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
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 KPHC.	Prenatal	93.5%	Yes	Yes	*Low Confidence*
	Postpartum	37.5%	No	Not Applicable	

According to HSAG's validation, the PIP was methodologically sound. The health plan achieved the SMART Aim goal for the prenatal measure; however, the health plan did not achieve the goal for postpartum care. The results remained below the baseline for postpartum care. HSAG assigned a level of *Low Confidence* to the PIP because both measures must achieve the SMART Aim goal.

Strengths and Weaknesses

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

For the *Improving Timeliness of Prenatal and Postpartum Care* PIP, HSAG assigned the health plan a level of *Low Confidence.* The health plan did not achieve the SMART Aim goal for the postpartum care measure.

AlohaCare QI identified the following key learnings from its two PIPs.

Getting Needed Care:

- Correlation between members who received the intervention and outcome scores was positive.
- Earlier initiation of the intervention would have helped for further analysis of the intervention.
- Pulling the report daily was too frequent and inefficient.
- Manually standardizing the intervention data is a process that needs to be automated when the intervention is documented in the care management system.

Improving Timeliness of Prenatal and Postpartum Care:

- Prenatal: The first intervention might have a greater impact on projects focused on preventive care such as well-child visits or cervical cancer screenings.
- Postpartum: The first intervention related to incentives could have benefitted from timely updates on community health worker rankings for the incentives. This may have created more excitement and overall engagement with the project.
- Postpartum: The most valuable information gained were the three indications for noncompliance: 1) no postpartum visit, 2) postpartum visit *after* compliancy period, and 3) postpartum visit *before* compliancy period.

Recommendations for Improvement

- AlohaCare QI should ensure that interventions for the PIP are started in a timely manner and evaluated quickly to impact the SMART Aim measure results by the SMART Aim end date.
- AlohaCare QI should continue to look for ways to obtain correct member contact information.
- AlohaCare QI should enlist the support of executive leadership in resolving delays and other issues with the PIP's provider partner, as needed.
- AlohaCare QI should ensure complete and accurate documentation of PIP results, including the monthly numerators and denominators for the SMART Aim measures and numerator and denominator data for the intervention effectiveness measures.

- AlohaCare QI should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Member Experience Analysis

Findings

Table 3-12 presents the 2019 percentage of top-box responses for AlohaCare QI compared to the 2018 NCQA child Medicaid national averages and the corresponding 2017 scores.[3-9,3-10,3-11] Additionally, the overall member experience ratings (i.e., star ratings) resulting from AlohaCare QI's top-box scores compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-12]

Table 3-12—Child Medicaid CAHPS Results *for* AlohaCare QI

Measure	2017 Scores	2019 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	67.3%	72.5%	★★★
Rating of All Health Care	62.5%	68.4%	★★
Rating of Personal Doctor	73.9%	76.5%	★★★
Rating of Specialist Seen Most Often	67.3%+	71.7%+	★★
Composite Measures			
Getting Needed Care	82.1%	82.2%	★★
Getting Care Quickly	83.8%	85.5%	★
How Well Doctors Communicate	91.9%	91.9%	★

[3-9] 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.
[3-10] The adult population was last surveyed in 2018; therefore, the 2019 child CAHPS scores are compared to the corresponding 2017 scores.
[3-11] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2018.
[3-12] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

Measure	2017 Scores	2019 Scores	Star Ratings
Customer Service	89.8%	87.1%+	★
Shared Decision Making	79.7%+	77.2%+	★★
Individual Item Measures			
Coordination of Care	79.5%+	81.3%+	★★
Health Promotion and Education	73.4%	79.4%	★★★★★

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child Medicaid national averages.
▲ Indicates the 2019 score is statistically significantly higher than the 2017 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
+ 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

Strengths

For AlohaCare QI's child Medicaid population, the following two measures met or exceeded the 2018 NCQA child Medicaid national averages:

- *Rating of Health Plan*
- *Health Promotion and Education*

In addition, one measure met or exceeded the 90th percentile, *Health Promotion and Education*.

None of the three MQD beneficiary satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—met or exceeded the 75th percentile for AlohaCare QI.

Areas for Improvement

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. 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 experience with each of the three measures; therefore, AlohaCare QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-13 provides a summary of the key drivers identified for AlohaCare QI.

Table 3-13—AlohaCare QI Key Drivers of Member Experience Analysis

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.	✓	✓	✓
Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.	✓	✓	✓
Respondents reported that it was often not easy for their child to obtain appointments with specialists.		✓	
Respondents reported that they did not always receive the information or help they needed from customer service at their child's health plan.	✓		
Respondents reported that forms from their child's health plan were often not easy to fill out.	✓		

The following observation from the key drivers of member experience analysis indicates an area for improvement in access for AlohaCare QI:

- Respondents reported that it was often not easy for their child to obtain appointments with specialists.

The following observations from the key drivers of member experience analysis indicate areas for improvement in quality of care for AlohaCare QI:

- Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.
- Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.
- Respondents reported that they did not always receive the information or help they needed from customer service at their child's health plan.
- Respondents reported that forms from their child's health plan were often not easy to fill out.

Overall Assessment of Quality, Access, and Timeliness of Care

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

Conclusions

In general, AlohaCare QI's performance results illustrate mixed performance across the four EQR activities. While the compliance monitoring review activity revealed that AlohaCare QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, AlohaCare QI had yet to fully implement the revised managed care regulations released in 2016. In addition, performance on outcome and process measures showed considerable room for improvement.

AlohaCare QI's performance during the 2019 compliance review was average, meeting or exceeding the statewide compliance score for four of the six standards. AlohaCare QI performed strongest in the *Access and Availability* standard with 100 percent compliance, and lowest in the *Member Grievance System* standard with 56 percent compliance. AlohaCare QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.

Overall, more than two-thirds (70.8 percent) of AlohaCare QI's measure rates fell below the 50th percentile across all domains, with almost half (47.7 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS 2018, AlohaCare QI's performance suggested several areas needing improvement including the Access to Care and Women's Health domains, where all of the measure rates were below the 50th percentile. None of AlohaCare QI's measure rates met the MQD's Quality Strategy targets.

Similarly, AlohaCare QI's CAHPS results illustrate opportunities for improvement in members' experiences with care. While none of the measures scored statistically significantly lower in 2019 than in 2017, the following eight measures were below the 50th percentiles: *Rating of All Health Care*, *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*. Additionally, nine of the 11 measures scored below the 2018 NCQA child Medicaid national averages: *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*.

Finally, the results of AlohaCare QI's PIPs indicate a need for ongoing quality improvement training of staff. Performance across the two PIPs was mixed, with the *Getting Needed Care* PIP being assessed with *High Confidence* while the *Improving Timeliness of Prenatal and Postpartum Care* PIP was assessed with *Low Confidence,* failing to reach its SMART Aim goal for the postpartum care measure. These results suggest that AlohaCare continues to have opportunities for improvement in executing the rapid-cycle PIP process but shows an ability to appropriately apply key quality improvement principles. Additionally, in 2019, AlohaCare QI submitted Module 1 and Module 2 for two new PIP topics specified by the MQD (*Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness*) and, at the time of this report, was in the process of resubmitting Module 1 and Module 2 to achieve all validation criteria before progressing to Module 3.

Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

Compliance Monitoring Review

The 2019 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-14 presents the standards and compliance scores for HMSA QI.

Table 3-14—Standards and Compliance Scores—HMSA QI

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	28	4	88%
II	Access and Availability	16	16	0	100%
III	Coordination and Continuity of Care	10	9	1	90%
IV	Member Rights and Protections	9	5	4	56%
V	Member Information	22	14	8	64%
VI	Member Grievance System	27	20	7	74%
	Totals	**116**	**92**	**24**	**79%**

Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.

Strengths

HMSA QI was found to be 100 percent compliant with the *Access and Availability* standard. The health plan had policies and procedures in place to monitor and measure the access and availability of primary medical care, behavioral healthcare, specialty care, and telephonic services. HMSA QI demonstrated implementation of its policies through assessing and reporting provider and geographic availability as well as the timeliness of access to appointments. HMSA QI regularly reviewed member-to-provider ratios in the required categories of PCPs and specialists, time/distance results, member complaints, and quarterly timely access survey results to identify network deficiencies.

HMSA QI also scored high with the Coordination and Continuity of Care standard with 90 percent compliance, with only one element scoring a *Not Met.* HMSA QI had policies and procedures that defined the health plan's overall Service Coordination program including organizational structure, staffing, scope of services, intake and assessment procedures, service plan development, and management and monitoring of the SHCN and LTSS populations. HMSA QI implemented three online

tools—i.e., Aerial (authorization and charting), Coreo Analytics (claims-driven analysis), and Coreo Coordinate (service plan and health and functional assessment [HFA])—to facilitate coordination efforts among HMSA departments and ensure the facilitation of services for members.

Areas for Improvement

HMSA QI was found to be compliant with 88 percent of the Coverage and Authorization of Services standard, with four elements scoring a *Not Met.* Overall, HMSA QI's policies and procedures provided evidence that it had mechanisms in place for managing and monitoring service coverage decisions to members and providers. However, in some areas, revisions were needed to better align the health plan's policies with the CFRs, specifically time frames for processing authorization decisions. In addition, member notification letter templates needed to be updated to include all federal and State required language.

HMSA QI was found to be compliant with 74 percent of the Member Grievance System standard, with seven elements scoring a *Not Met.* While HMSA QI had comprehensive policies and procedures for the processing of grievances and appeals, many of the processes and time frames used by the health plan were not in alignment with the current federal regulations and State contracts. The corrective actions required by HMSA QI were related to updating policies, procedures, member notification letter templates, and provider information to be in compliance with federal and State regulations.

HMSA QI was found to be 64 percent compliant with the Member Information standard, with eight elements scoring a *Not Met.* In general, HMSA QI had member information, customer service staff members, and service coordinators available to help members understand the requirements and benefits of the plan. The corrective actions required by HMSA QI were related to member handbook updates to ensure correct information was provided to members, provider directory updates to include all required elements, and implementing processes to evaluate the health plan's website and member documents to ensure information was readily accessible to all members.

HMSA QI was found to be 56 percent compliant with the Member Rights and Protections standard, with four elements scoring a *Not Met.* The health plan's member rights policy and member handbook were missing several required member rights. In addition, HMSA QI had yet to establish a member advisory committee that included LTSS members or others representing these members.

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. 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 supplemental data sources for its performance measure reporting.

No concerns were identified, and these data sources were approved for HEDIS 2019 measure reporting. All convenience samples passed HSAG's review.

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

- HMSA QI confirmed that data from 'Ohana was not incorporated for any HEDIS or state-specific measure rate reporting for the CCS population. HSAG recommends that the data be included for future rate reporting.
- HSAG recommended HMSA should continue to identify ways to improve its medical record over-read process to avoid any critical 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. For HMSA QI reporting, the *Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia* and *Follow-Up After Emergency Department Visit for Mental Illness* 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—*Controlling High Blood Pressure*
- Group B: Anticipatory Guidance & Counseling—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (Total)*
- Group C: Laboratory—*Cervical Cancer Screening (CCS), Comprehensive Diabetes Care (CDC)—HbA1c Control <8.0%, CDC—HbA1c Poor Control >9.0%, CDC—Medical Attention for Nephropathy, and CDC—HbA1c Testing*
- Group D: Immunization & Other Screenings—*IMA Combo 3*

Access to Care Performance Measure Results

HMSA QI's Access to Care 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 HEDIS 2019. Overall, five of 10 measure rates that could be compared to benchmarks ranked at or above the 50th percentile. Conversely, all four *Adults' Access to Preventive/Ambulatory Health Services* rates fell below the 50th percentile, with three of these rates falling below the 25th percentile. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2019.

Table 3-15—HMSA QI's HEDIS Results for QI Measures Under Access to Care

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adults' Access to Preventive/Ambulatory Health Services[1]				
20–44 Years	70.26%	71.21%	1.35%	★
45–64 Years	81.40%	81.95%	0.68%	★
65 Years and Older	86.42%	84.90%	-1.76%	★★
Total	74.78%	75.53%	1.00%	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	96.43%	97.21%	0.81%	★★★★
25 Months–6 Years	89.27%	88.67%	-0.67%	★★★
7–11 Years	91.61%	90.70%	-0.99%	★★★
12–19 Years	89.52%	89.97%	0.50%	★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	36.97%	35.60%	-3.71%	★
Engagement of AOD Treatment—Total	15.36%	14.52%	-5.47%	★★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.*

2019 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 3-16. Five measure rates in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, six measure rates ranked at or above the 50th percentile. Conversely, 14 measure rates fell below the 50th percentile, with five of these rates falling below the 25th percentile. One measure rate demonstrated a relative decline of more than 10 percent in HEDIS 2019. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2019 (i.e., *Childhood Immunization Status—Combination 3*), and HMSA QI did not meet the established target, the 75th percentile.

Table 3-16—HMSA QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	48.18%	52.80%	9.59%	★★
Childhood Immunization Status[1]				

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Combination 3	75.91%	71.53%	-5.77%	★★★
DTaP	81.02%	77.86%	-3.90%	★★★
Hepatitis B	86.62%	86.13%	-0.57%	★
HiB	89.78%	88.32%	-1.63%	★★
IPV	87.83%	87.10%	-0.83%	★★
MMR	90.02%	89.05%	-1.08%	★★
Pneumococcal Conjugate	80.29%	76.64%	-4.55%	★★
VZV	88.81%	86.62%	-2.47%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	59.85%	66.42%	10.98%	★
Combination 2 (Meningococcal, Tdap, HPV)	25.06%	28.71%	14.57%	★★
HPV	27.74%	31.63%	14.02%	★★
Meningococcal	63.02%	69.59%	10.43%	★
Tdap	66.91%	70.80%	5.81%	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	0.93%	1.72%	84.95%	★★
Six or More Well-Child Visits	70.09%	71.26%	1.67%	★★★
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	78.66%	71.18%	-9.51%	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	83.94%	85.11%	1.39%	★★★★
Counseling for Nutrition—Total	73.72%	75.93%	3.00%	★★★
Counseling for Physical Activity—Total	57.66%	71.22%	23.52%	★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
2019 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 3-17. One rate in this domain reported a relative improvement of more than 10 percent in HEDIS 2019. Two measure rates ranked at or above the 50th percentile. Conversely, five measure rates fell below the 50th percentile,

with two of these rates falling below the 25th percentile. Three measures[3-13] in this domain had MQD Quality Strategy targets for HEDIS 2019. None of HMSA QI's measure rates met or exceeded the established MQD Quality Strategy targets.

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

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Breast Cancer Screening[1]				
Breast Cancer Screening	62.07%	60.23%	-2.96%	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	65.00%	63.30%	-2.62%	★★★
Chlamydia Screening in Women				
16–20 Years	51.74%	48.52%	-6.22%	★★
21–24 Years	56.10%	56.43%	0.59%	★
Total	53.77%	52.29%	-2.75%	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	71.29%	77.62%	8.88%	★★
Postpartum Care	49.15%	55.72%	13.37%	★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years..
2019 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 3-18. One rate in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, three measure rates ranked at or above the 50th percentile, including one rate that ranked above the 75th percentile. Conversely, two rates in this domain demonstrated a relative decline of more than 10 percent in HEDIS 2019, and five measure rates fell below the 25th percentile. Seven measures[3-14] within this domain had an MQD Quality Strategy target for HEDIS 2019, with HMSA QI meeting or exceeding the target for one measure (*Comprehensive Diabetes Care—Eye Exam [Retinal] Performed*).

[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*.
[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).

Table 3-18—HMSA QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	83.76%	85.60%	2.20%	★
Diuretics	83.44%	85.05%	1.93%	★
Total	83.66%	85.42%	2.10%	★
Comprehensive Diabetes Care[1]				
HbA1c Testing	84.33%	87.35%	3.58%	★★
*HbA1c Poor Control (>9.0%)**	40.85%	42.82%	4.82%	★★
HbA1c Control (<8.0%)	48.94%	43.80%	-10.50%	★
Eye Exam (Retinal) Performed	62.85%	67.15%	6.84%	★★★★
Medical Attention for Nephropathy	88.20%	89.54%	1.52%	★★
Blood Pressure Control (<140/90 mm Hg)	59.15%	48.66%	-17.73%	★
Controlling High Blood Pressure[2]				
Controlling High Blood Pressure	—	53.28%	—	NC
Medication Management for People With Asthma[1]				
Medication Compliance 50%—Total	58.74%	61.97%	5.50%	★★★
Medication Compliance 75%—Total	36.49%	41.04%	12.47%	★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 3-19. One rate in this domain demonstrated a relative improvement of more than 10 percent for HEDIS 2019. Additionally, eight measure rates ranked at or above the 50th percentile, with two of these rates ranking above the 75th percentile. Conversely, two rates in this domain reported a relative decline of more than 10 percent in HEDIS 2019. Additionally, five measure rates fell below the 50th percentile, with one of these rates

falling below the 25th percentile. Two measures[3-15] in this domain had an MQD Quality Strategy target for HEDIS 2019, and HMSA QI did not reach the established targets, the 75th percentile.

Table 3-19—HMSA QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	47.67%	50.40%	5.73%	★★
Effective Continuation Phase Treatment	32.08%	33.91%	5.70%	★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia[1]				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	—	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[1]				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	68.45%	69.59%	1.67%	★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7 Day Follow-Up—13–17 Years	12.90%	9.09%	-29.53%	★★★
7 Day Follow-Up—18+ Years	16.38%	15.40%	-5.98%	★★★
7 Day Follow-Up—Total	16.14%	14.91%	-7.62%	★★★
30 Day Follow-Up—13–17 Years	14.52%	9.09%	-37.40%	★★★
30 Day Follow-Up—18+ Years	24.88%	22.85%	-8.16%	★★★
30 Day Follow-Up—Total	24.15%	21.78%	-9.81%	★★★
Follow-Up After ED Visit for Mental Illness[2]				
7-Day Follow-Up—Total	—	30.51%	—	NC
30-Day Follow-Up—Total	—	47.02%	—	NC
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—Total	36.94%	35.32%	-4.39%	★★
30-Day Follow-Up—Total	55.99%	53.82%	-3.88%	★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	51.96%	51.92%	-0.08%	★★★★
Continuation and Maintenance Phase	57.97%	66.67%	15.01%	★★★★
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness				
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	36.24%	36.70%	1.26%	NC

[3-15] Within this domain, there were two MQD Quality Strategy targets: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total.*

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 for HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, a relative difference could not be calculated, 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.
2019 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 3-20. Excluding *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*, *ED Visits for Ambulatory Care Sensitive Conditions*, 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 *Plan All-Cause Readmissions*, one measure rate demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, all four *Plan All-Cause Readmissions* measure rates ranked at or above the 75th percentile, with one of these rates exceeding the 90th percentile; however, two of the measure rates demonstrated a relative increase of more than 10 percent, indicating worse performance. Neither of the *ED Visits for Ambulatory Care Sensitive Conditions* measure rates demonstrated a relative improvement (decrease) of more than 10 percent in HEDIS 2019. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure met or exceeded the MQD Quality Strategy target for HEDIS 2019, the 90th percentile.

Table 3-20—HMSA QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	42.11	38.59	-8.36%	★★★★★
Outpatient Visits—Total[1]	327.07	299.96	-8.29%	NC
ED Visits for Ambulatory Care Sensitive Conditions*				
*PCP Treatable ED Visits**	11.43%	11.88%	3.93%	NC
*Preventable/Avoidable ED Visits**	69.32%	69.76%	0.64%	NC
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	51.67%	50.62%	-2.03%	NC
20–44 Years Subtotal Percentage—Total	29.87%	30.91%	3.48%	NC
45–64 Years Subtotal Percentage—Total	16.68%	16.32%	-2.16%	NC

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
65+ Years Subtotal Percentage—Total	1.78%	2.15%	20.79%	NC
Inpatient Utilization—General Hospital/Acute Care—Total[1]				
Maternity—Average Length of Stay—Total	2.52	2.53	0.40%	NC
Maternity—Days per 1,000 Member Months—Total	6.07	5.76	-5.11%	NC
Maternity—Discharges per 1,000 Member Months—Total	2.41	2.28	-5.39%	NC
Medicine—Average Length of Stay—Total	4.71	5.27	11.89%	NC
Medicine—Days per 1,000 Member Months—Total	10.27	10.85	5.65%	NC
Medicine—Discharges per 1,000 Member Months—Total	2.18	2.06	-5.50%	NC
Surgery—Average Length of Stay—Total	7.75	7.25	-6.45%	NC
Surgery—Days per 1,000 Member Months—Total	7.25	6.37	-12.14%	NC
Surgery—Discharges per 1,000 Member Months—Total	0.94	0.88	-6.38%	NC
Total Inpatient—Average Length of Stay—Total	4.54	4.68	3.08%	NC
Total Inpatient—Days per 1,000 Member Months—Total	21.75	21.29	-2.11%	NC
Total Inpatient—Discharges per 1,000 Member Months—Total	4.79	4.55	-5.01%	NC
Mental Health Utilization[2]				
Any Service—Total	—	10.86%	—	NC
Inpatient—Total	—	0.41%	—	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.05%	—	NC
Outpatient—Total	—	10.65%	—	NC
*ED—Total**	—	0.22%	—	NC
Telehealth—Total	—	0.18%	—	NC
Plan All-Cause Readmissions[1]				
*Index Total Stays—Observed Readmissions—Ages 18–44**	10.05%	11.92%	18.61%	★★★★
*Index Total Stays—Observed Readmissions—Ages 45–54**	10.87%	12.50%	15.00%	★★★★

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
*Index Total Stays—Observed Readmissions—Ages 55–64**	12.19%	9.98%	-18.13%	★★★★★
*Index Total Stays—Observed Readmissions—Total**	10.90%	11.49%	5.41%	★★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 66 measure rates comparable to benchmarks, 29 measure rates (43.9 percent) ranked at or above the 50th percentile, with 10 of these rates (15.2 percent) ranking above the 75th percentile, indicating positive performance in access to care for infants, weight assessments for children and adolescents, appropriate eye exams for diabetic members, appropriate follow-up care for children prescribed ADHD medication, and low ED utilization and readmissions. Additionally, HMSA QI met two of the MQD Quality Strategy targets for HEDIS 2019.

Conversely, 37 of HMSA QI's measure rates comparable to benchmarks (56.1 percent) fell below the 50th percentile, with 17 of these rates (25.8 percent) falling 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 25th percentile for the QI population:

- Access to Care
  - *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *45–64 Years*, and *Total*
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
- Children's Preventive Health
  - *Childhood Immunization Status—Hepatitis B* and *VZV*
  - *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, *Meningococcal*, and *Tdap*

- Women's Health
  - *Chlamydia Screening in Women—21–24 Years*
  - *Prenatal and Postpartum Care—Postpartum Care*
- Care for Chronic Conditions
  - *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics*, and *Total*
  - *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)*
- Behavioral Health
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Validation of Performance Improvement Projects

Findings

Getting Needed Care PIP

HMSA QI's focus for this PIP was to increase the percentage of members under the age of 18 who had an office visit for dermatology, ophthalmology, or psychiatry and responded positively on the survey that the member could get an appointment as soon as needed. Details of HMSA QI's interventions for the PIP are presented in Table 3-21 and in the narrative below.

Table 3-21—Intervention Testing for *Getting Needed Care* PIP

Interventions	Key Drivers	Failure Modes	Conclusion
1. Online Referral Tool	• Appointment availability • Communication barriers	Provider does not have a quicker system to send a referral	The health plan chose to *abandon* the intervention.
2. Appointment Tips Brochure	Member knowledge of available resources, involvement in care, and communication barriers between the member and provider/health plan	Members do not seek care due to an expectation of improvement of illness, time constraints, and issues finding an appointment time	The health plan chose to *abandon* the intervention.

Before starting the first intervention, an online referral tool, the health plan eliminated the need for a specialist referral and abandoned the intervention. The second intervention was a tips brochure for children and parents to use as a guide to prepare for scheduling an appointment with a specialist. The health plan was only able to report intervention effectiveness data for December 2018.

The health plan concluded:

- A specialist referral would not be required. Due to the inability to execute the online referral tool, there were no testing results.
- Due to minimal responses from the mailers, HMSA QI abandoned the brochure intervention and planned to test a text messaging outreach.

HSAG validated HMSA QI's *Getting Needed Care* PIP SMART Aim measure rates based on the results in Module 5. Table 3-22 below provides the level of confidence HSAG assigned to the PIP.

Table 3-22—SMART Aim Results for *Getting Needed Care* PIP

SMART Aim	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
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 you child get an appointment to see Dr. <FName><LName> as soon as you needed?" from 93% to 98%.	100%	Yes	No	*Low Confidence*

The health plan's results for the SMART Aim measure exceeded the goal for four months during 2018; however, an intervention tested for the PIP could not be linked to the improvement. Therefore, HSAG assigned the PIP a level of *Low Confidence*.

Improving Timeliness of Prenatal and Postpartum Care PIP

HMSA QI's focus for this PIP was to increase the rate of members receiving timely prenatal care and postpartum care appointments. HMSA QI submitted two interventions for prenatal care and two interventions for postpartum care as part of the rapid-cycle PIP. Details of HMSA QI's interventions for the PIP are presented in Table 3-23 and in the narrative below.

Table 3-23—Intervention Testing for *Improving Timeliness of Prenatal and Postpartum Care* PIP

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
1. Telephonic Deadline Reminders	Adherence to appointment scheduling	Member does not follow up with insurance process in a timely manner	The health plan chose to *abandon* the intervention.

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
2. Text Messaging	• Understanding the importance of care visits • Adherence to appointment scheduling	• Member does not receive sufficient information in the member's fluent language • Member is not interested in understanding the information provided	The health plan chose to *continue testing* the intervention.
Postpartum Interventions	**Key Drivers**	**Failure Modes**	**Conclusion**
1. Translation/Interpretation Services	Communication barriers between member and provider/health plan	Member does not receive sufficient information in the member's fluent language	The health plan chose to *abandon* the intervention.
2. Text Messaging	• Understanding the importance of care visits • Adherence to appointment scheduling	• Member does not receive sufficient information in the member's fluent language • Member is not interested in understanding the information provided	The health plan chose to *continue testing* the intervention.

The health plan began Module 4 by submitting two intervention plans—telephonic deadline reminders for prenatal care and translation/interpretation services for postpartum care. The health plan abandoned these interventions, and no data were reported. HMSA QI tested another intervention for both prenatal and postpartum care—text messaging. The change began in July 2018.

The health plan concluded:

- Waimanalo Health Center did not refer members to the Pregnancy Support Program during the initial testing period.
- Due to the inability to provide a translation line without requiring a paid contract for outside participating health centers and the lag in response time from participating health centers, HMSA QI has decided to abandon the intervention.
- The text messaging pilot sustained an average of 15 percent to 20 percent member participation. According to HealthCrowd, an average of 15 percent of members participate in the text messaging based on experience with other health plans.

HSAG validated HMSA QI's *Improving Timeliness of Prenatal and Postpartum Care* PIP SMART Aim measure rates based on the results in Module 5. Table 3-24 provides the level of confidence HSAG assigned to the PIP.

Table 3-24—Status of the *Improving Timeliness of Prenatal and Postpartum Care* PIP

SMART Aim	Measure	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
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%.	Prenatal	75.0%	Yes	No	*Low Confidence*
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%.	Postpartum	33.3%	Yes	No	

For the prenatal SMART Aim measure results, the November 2018 result reached the SMART Aim goal after intervention testing began. For postpartum care, some results prior to testing the intervention were above the goal; however, there was a continual decline in the rate after the intervention began. HSAG assigned the PIP a level of *Low Confidence*.

Strengths and Weaknesses

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

HMSA QI identified the following key learnings from its two PIPs:

Getting Needed Care:

- Mailed materials affect time-sensitive projects due to needing approvals.
- HMSA QI will work to outreach members through different platforms such as text messaging. The response rate is higher for text messages than for mailers.

Improving Timeliness of Prenatal and Postpartum Care:

- HMSA QI outreached members through mailers/surveys and text messaging. According to the responses and engagement of the members, text messaging seems to be a preferred method of outreach/interaction between the health plan and members.

Recommendations for Improvement

- HMSA QI should ensure that the results and interpretation are provided accurately and completely in the PIP documentation.
- HMSA QI should ensure that interventions tested for the rapid-cycle PIP reach enough members to impact the SMART Aim, and that data can provide a clear linkage between improvement in the SMART Aim measure results and change(s) tested for the PIP.
- HMSA QI should start testing interventions for the PIP in a timely manner, allowing enough time to impact the SMART Aim measure results by the SMART Aim end date. If delays occur, the health plan may not have incurred enough data points by the SMART Aim end date.
- HMSA QI should select active, innovative interventions to test for the rapid-cycle PIP. Mailings are considered passive changes that are not likely to impact the results.
- HMSA QI should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Member Experience Analysis

Findings

Table 3-25 presents the 2019 percentage of top-box responses for HMSA QI compared to the 2018 NCQA child Medicaid national averages and the corresponding 2017 scores.[3-16,3-17,3-18] Additionally, the overall member experience ratings (i.e., star ratings) resulting from HMSA QI's top-box scores compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-19]

Table 3-25—Child Medicaid CAHPS Results *for* HMSA QI

Measure	2017 Scores	2019 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	73.6%	74.1%	★★★
Rating of All Health Care	69.8%	72.3%	★★★
Rating of Personal Doctor	74.6%	78.1%	★★★
Rating of Specialist Seen Most Often	72.6%+	74.5%+	★★★
Composite Measures			
Getting Needed Care	87.0%	82.0%	★★
Getting Care Quickly	91.0%	87.0%	★★
How Well Doctors Communicate	95.4%	96.3%	★★★★
Customer Service	87.7%	86.4%+	★
Shared Decision Making	80.6%+	82.6%+	★★★★
Individual Item Measures			
Coordination of Care	84.4%	80.8%+	★★
Health Promotion and Education	77.3%	73.4%	★★★

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child Medicaid national averages.
▲ Indicates the 2019 score is statistically significantly higher than the 2017 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
+ 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

[3-16] 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.
[3-17] The adult population was last surveyed in 2018; therefore, the 2019 child CAHPS scores are compared to the corresponding 2017 scores.
[3-18] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2018.
[3-19] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

Strengths

For HMSA QI's child Medicaid population, the following seven measures met or exceeded the 2018 NCQA child Medicaid national averages:

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

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 experience rating for *How Well Doctors Communicate* met or exceeded the 75th percentile.

Areas for Improvement

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. 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 experience with each of the three measures; therefore, HMSA QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-26 provides a summary of the key drivers identified for HMSA QI.

Table 3-26—HMSA QI Key Drivers of Member Experience Analysis

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.	✓	✓	
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.	✓		
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.			✓

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.	✓	✓	✓
Respondents reported that it was often not easy for their child to obtain appointments with specialists.		✓	

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

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

The following observations from the key drivers of member experience analysis indicate areas for improvement in quality of care for HMSA QI:

- Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.
- Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.
- Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.

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 four EQR activities. While the compliance monitoring review activity revealed that HMSA QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, HMSA QI had yet to fully implement the revised managed care regulations released in 2016. In addition, performance on outcome and process measures showed room for improvement.

HMSA QI's performance during the 2019 compliance review was average, meeting or exceeding the statewide compliance score for four of the six standards. HMSA QI performed strongest in the *Access and Availability* standard with 100 percent compliance and lowest in the *Member Rights and Protections* standard with 56 percent compliance. HMSA QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor HMSA QI's CAP activities until the health plan is found to be in full compliance.

Overall, more than half (56.1 percent) of HMSA QI's measures fell below the 50th percentile across all domains, with over one-quarter (25.8 percent) of measure rates falling below the 25th percentile. While some measure rates showed improvement from HEDIS 2018, HMSA QI's performance suggested several areas of improvement across all domains of care. Overall, only two of the MQD's Quality Strategy targets were met in HEDIS 2019.

Similarly, HMSA QI's CAHPS results illustrate opportunities for improvement in members' experiences with care. While none of the measures scored statistically significantly lower in 2019 than in 2017, the following four measures were below the 50th percentiles and the 2018 NCQA child Medicaid national averages: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Coordination of Care*.

Finally, the results of HMSA QI's PIPs indicate a need for ongoing quality improvement training of staff. HSAG assessed HMSA QI's *Getting Needed Care* and *Improving Timeliness of Prenatal and Postpartum Care* PIPs both as *Low Confidence.* While the validation findings determined that HMSA QI met the SMART Aim goals for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. These results suggest that HMSA QI continues to have opportunities for improvement in executing the rapid-cycle PIP process Additionally, in 2019, HMSA QI submitted Module 1 and Module 2 for two new PIP topics specified by the MQD (*Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness)* and, at the time of this report, was in the process of resubmitting Module 1 and Module 2 to achieve all validation criteria before progressing to Module 3.

While the compliance findings suggest HMSA QI's strength related to the *Access and Availability* and *Coordination and Continuity of Care* standards, the MCO's HEDIS measure performance in the access to care and children's preventive health measures, coupled with the less-than-average CAHPS performance in access to care and care coordination-related measures, suggest opportunities for improvement for HMSA QI for both access to care and quality of care. This is further supported by HMSA QI's performance on the *Getting Needed Care* and *Improving Timeliness of Prenatal and Postpartum Care* PIPs, which were assessed as *Low Confidence* as the interventions could not be linked to improvement. Poor performance related to prenatal and postpartum care may also indicate barriers in accessing needed care before and after delivery. Since CAHPS survey measures assess members' perceptions, poor performance on the *Getting Needed Care*, *Getting Care Quickly*, and *Coordination of Care* measures indicates that members perceive barriers when accessing care. These perceptions may be confirmed when access-related measures, such as *Adults' Access to Preventive/Ambulatory Health Services* and *Children's Preventive Health*, fail to meet the national average.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

Compliance Monitoring Review

The 2019 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-27 presents the standards and compliance scores for KFHP QI.

Table 3-27—Standards and Compliance Scores—KFHP QI

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	24	8	75%
II	Access and Availability	16	14	2	88%
III	Coordination and Continuity of Care	10	8	2	80%
IV	Member Rights and Protections	9	5	4	56%
V	Member Information	22	13	9	59%
VI	Member Grievance System	27	19	8	70%
	Totals	**116**	**83**	**33**	**72%**

Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.

Strengths

KFHP QI was found to be 88 percent compliant with the *Access and Availability* standard, with two elements scoring a *Not Met*. The health plan had the structures, systems, and processes in place to regularly evaluate and monitor access to and availability of services and network providers for enrolled members. KFHP QI implemented systems and tools to monitor and evaluate geographic accessibility (by time and distance) and timeliness of appointments by region and QI population. Due to KFHP QI's delivery of care/services model, staff were able to assess appointment availability using clinical appointment data instead of traditional member and provider survey methods yielding more detailed information for managing and leveraging network resources. The corrective actions required by KFHP QI were related to policy and procedure updates to include state-defined access and availability standards and updates to the member handbook related to second opinions.

Areas for Improvement

KFHP QI was found to be 80 percent compliant with the Coordination and Continuity of Care standard, with two elements scoring a *Not Met.* KFHP QI had policies and procedures that described how the

health plan met the requirements for compliance with federal and state regulations governing the coordination and continuity of care. Service coordination systems and processes were in place to assess, plan, implement, coordinate, and monitor care provided to members through the health plan's service coordination program. KFPH QI implemented a distributed model that placed service coordinators within the communities they served to facilitate collaboration with members and their caregivers and ensure integration with KFHP QI medical and social supports. The corrective actions required by KFHP QI were related to policy and procedure updates to accurately describe current care coordination processes.

KFHP QI was found to be compliant with 75 percent of the Coverage and Authorization of Services standard, with eight elements scoring a *Not Met.* Although KFHP QI's submitted documentation addressed the health plan's policies and procedures for utilization management, including the criterion for placing appropriate limits on services, its documentation omitted key additions related to previous updates to the CFRs. In addition, timelines outlined in the CFRs for the reduction, suspension, and termination of authorizations were not followed by KFHP. The corrective actions required by KFHP QI included policy and procedure updates to align with current CFRs and State requirements as well as member notification letter template updates to include all required information.

KFHP QI was found to be compliant with 70 percent of the Member Grievance System standard, with eight elements scoring a *Not Met.* While KFHP QI had several comprehensive policies and procedures for the processing of grievances and appeals, some definitions and time frames did not align with current federal regulations and State contracts. The corrective actions required by KFHP QI were related to updating policies, procedures, member notification letter templates, and provider information to be in compliance with federal and State regulations.

KFHP QI was found to be 59 percent compliant with the Member Information standard, with nine elements scoring a *Not Met.* In general, KFHP QI had member information, customer service staff members, and service coordinators available to help members understand the requirements and benefits of the plan. The corrective actions required by KFHP QI were related to member handbook updates to ensure correct information was provided to members, implementing processes to ensure timely updates to provider directories and formularies, provider directory updates to ensure all required elements were included, and implementing processes to evaluate the health plan's website and member documents to ensure information was readily accessible to all members.

KFHP QI was found to be 56 percent compliant with the Member Rights and Protections standard, with four elements scoring a *Not Met.* The health plan's member rights policy and member handbook were missing several required member rights. In addition, KFHP QI had yet to establish a member advisory committee that included LTSS members or others representing LTSS members.

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 2019 measure reporting. All convenience samples passed HSAG's review.

The auditors did not have any recommendations for KFHP QI.

All QI measures which KFHP QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted. For KFHP QI reporting, the *Cardiovascular Monitoring for People with Cardiovascular Disease* and *Schizophrenia, Follow-Up After Emergency Department Visit for Mental Illness*, *Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence,* and *Follow-Up Care for Children Prescribed ADHD Medication* measure indicators received a designation of *Small Denominator* (NA).

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—*Controlling High Blood Pressure* and *Prenatal Postpartum Care (PPC)—Timeliness of Prenatal Care*
- Group B: Anticipatory Guidance & Counseling—*Adolescent Well-Care Visits* and *Weight Assessment and Counseling for Nutrition* and *Physical Activity for Children/Adolescents-Counseling for Physical Activity (Total)*
- Group D: Immunization & Other Screenings—*Comprehensive Diabetes Care (CDC)-Eye Exam (Retinal) Performed*

Access to Care Performance Measure Results

KFHP QI's Access to Care performance measure results are shown in Table 3-28. Overall, six measure rates ranked at or above the 50th percentile, with three of these rates exceeding the 90th percentile. Conversely, four measure rates fell below the 50th percentile, with two of these rates falling below the 25th percentile and demonstrating a relative decline of more than 10 percent in HEDIS 2019. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2019.

Table 3-28—KFHP QI's HEDIS Results for QI Measures Under Access to Care

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adults' Access to Preventive/Ambulatory Health Services[1]				
20–44 Years	74.14%	80.68%	8.82%	★★★
45–64 Years	83.64%	90.07%	7.69%	★★★★
65 Years and Older	94.92%	96.68%	1.85%	★★★★★
Total	78.70%	85.10%	8.13%	★★★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	99.23%	98.67%	-0.56%	★★★★★
25 Months–6 Years	92.97%	92.92%	-0.05%	★★★★★
7–11 Years	92.26%	88.38%	-4.21%	★★
12–19 Years	90.99%	87.90%	-3.40%	★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	41.95%	33.19%	-20.88%	★
Engagement of AOD Treatment—Total	13.83%	8.35%	-39.62%	★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.*

2019 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 3-29. One rate in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Eleven measure rates ranked at or above the 75th percentile, with seven of these rates exceeding the 90th percentile. An additional seven measure rates ranked at or above the 50th percentile. Conversely, two measure rates fell below the 50th percentile, with one of these rates falling below the 25th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2019 (i.e., *Childhood Immunization Status—Combination 3*), and KFHP QI exceeded the established target, the 75th percentile.

Table 3-29—KFHP QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	43.31%	42.34%	-2.24%	★
Childhood Immunization Status[1]				

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Combination 3	80.24%	81.17%	1.16%	★★★★★
DTaP	83.85%	83.50%	-0.42%	★★★★
Hepatitis B	92.39%	92.26%	-0.14%	★★★
HiB	90.79%	90.07%	-0.79%	★★★
IPV	92.26%	91.68%	-0.63%	★★★
MMR	91.59%	90.80%	-0.86%	★★★
Pneumococcal Conjugate	81.71%	82.34%	0.77%	★★★★
VZV	90.92%	90.51%	-0.45%	★★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	82.15%	83.98%	2.23%	★★★
Combination 2 (Meningococcal, Tdap, HPV)	42.96%	47.08%	9.59%	★★★★★
HPV	44.77%	47.63%	6.39%	★★★★
Meningococcal	84.94%	85.24%	0.35%	★★★
Tdap	83.82%	86.35%	3.02%	★★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	0.57%	0.46%	-19.30%	★★★★★
Six or More Well-Child Visits	78.97%	74.92%	-5.13%	★★★★
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	82.36%	86.53%	5.06%	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	93.40%	95.83%	2.60%	★★★★★
Counseling for Nutrition—Total	100.00%	98.33%	-1.67%	★★★★★
Counseling for Physical Activity—Total	100.00%	97.50%	-2.50%	★★★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
2019 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 3-30. None of the rates in this domain reported a relative improvement or decline of more than 10 percent in HEDIS 2019. All

seven measure rates exceeded the 90th percentile. There were three measures[3-20] in this domain with MQD Quality Strategy targets for HEDIS 2019. KFHP QI met or exceeded all three established MQD Quality Strategy targets, the 75th percentile.

Table 3-30—KFHP QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Breast Cancer Screening[1]				
Breast Cancer Screening	75.34%	79.03%	4.90%	★★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	79.39%	78.51%	-1.11%	★★★★★
Chlamydia Screening in Women				
16–20 Years	78.26%	77.28%	-1.25%	★★★★★
21–24 Years	80.63%	82.06%	1.77%	★★★★★
Total	79.21%	79.41%	0.25%	★★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	90.00%	92.59%	2.88%	★★★★★
Postpartum Care	80.46%	80.37%	-0.11%	★★★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
2019 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 3-31. Two rates in this domain reported a relative improvement of more than 10 percent in HEDIS 2019. Additionally, eight measure rates ranked at or above the 75th percentile, with three of these rates exceeding the 90th percentile. Conversely, two measure rates fell below the 50th percentile. There were seven 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 five measures, all related to *Comprehensive Diabetes Care.*

[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*.
[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). Due to technical specification changes in 2019, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Controlling High Blood Pressure* measure.

Table 3-31—KFHP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	91.37%	92.25%	0.96%	★★★★
Diuretics	90.09%	92.37%	2.53%	★★★★
Total	90.96%	92.28%	1.45%	★★★★
Comprehensive Diabetes Care[1]				
HbA1c Testing	92.91%	94.59%	1.81%	★★★★★
*HbA1c Poor Control (>9.0%)**	30.39%	33.11%	8.95%	★★★
HbA1c Control (<8.0%)	57.99%	56.16%	-3.16%	★★★★
Eye Exam (Retinal) Performed	68.43%	66.91%	-2.22%	★★★★
Medical Attention for Nephropathy	94.42%	95.20%	0.83%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	77.55%	79.08%	1.97%	★★★★★
Controlling High Blood Pressure[2]				
Controlling High Blood Pressure	—	77.62%	—	NC
Medication Management for People With Asthma[1]				
Medication Compliance 50%—Total	48.89%	58.85%	20.37%	★★
Medication Compliance 75%—Total	28.08%	31.86%	13.46%	★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, a relative difference could not be calculated, 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.
2019 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

KFHP QI's Behavioral Health performance measure results are shown in Table 3-32. Two measures in this domain had an MQD Quality Strategy target for HEDIS 2019, and KFHP QI met or exceeded both of the established targets, the 75th percentile.

Three rates reported a relative improvement of more than 10 percent in HEDIS 2019. Six measure rates ranked at or above the 75th percentile, with two of these rates exceeding the 90th percentile. Conversely, five rates in this domain had a relative decline of more than 10 percent in HEDIS 2019, with four of these rate declines occurring for the *Follow-Up After ED Visit for AOD Abuse or Dependence* measure. Two measures[3-22] in this domain had an MQD Quality Strategy target for HEDIS 2019, and KFHP QI met or exceeded both of the established targets, the 75th percentile.

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

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	48.50%	64.53%	33.05%	★★★★
Effective Continuation Phase Treatment	34.96%	43.24%	23.68%	★★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia[1]				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	—	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[1]				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.00%	85.60%	0.71%	★★★★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7 Day Follow-Up—13–17 Years	NA	NA	—	NC
7 Day Follow-Up—18+ Years	19.74%	12.20%	-38.20%	★★★
7 Day Follow-Up—Total	18.28%	14.29%	-21.83%	★★★
30 Day Follow-Up—13–17 Years	NA	NA	—	NC
30 Day Follow-Up—18+ Years	28.95%	17.07%	-41.04%	★★★
30 Day Follow-Up—Total	25.81%	18.68%	-27.62%	★★★
Follow-Up After ED Visit for Mental Illness[2]				
7-Day Follow-Up—Total	—	38.97%	—	NC
30-Day Follow-Up—Total	—	58.09%	—	NC
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—Total	55.00%	56.64%	2.98%	★★★★★
30-Day Follow-Up—Total	74.29%	68.14%	-8.28%	★★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	66.67%	74.36%	11.53%	★★★★★
Continuation and Maintenance Phase	NA	NA	—	NC

[3-22] Within this domain, there were two MQD Quality Strategy targets: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total.*

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness				
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	32.56%	18.03%	-44.62%	NC

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 for HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, a relative difference could not be calculated, 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.
2019 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 3-33. Excluding *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*, *ED Visits for Ambulatory Care Sensitive Conditions*, 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 *Plan All-Cause Readmissions*, one measure rate demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, all four *Plan All-Cause Readmissions* measure rates ranked at or above the 75th percentile, with one of these rates exceeding the 90th percentile. Neither of the *ED Visits for Ambulatory Care Sensitive Conditions* measure rates demonstrated a relative improvement or decrease of more than 10 percent in HEDIS 2019. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure met or exceeded the MQD Quality Strategy target for HEDIS 2019, the 90th percentile.

Table 3-33—KFHP's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	31.51	32.97	4.63%	★★★★★
Outpatient Visits—Total[1]	264.18	530.40	100.77%	NC
ED Visits for Ambulatory Care Sensitive Conditions*				
PCP Treatable ED Visits	11.72%	11.81%	0.79%	NC

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Preventable/Avoidable ED Visits	68.32%	68.94%	0.91%	NC
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	56.63%	55.63%	-1.77%	NC
20–44 Years Subtotal Percentage—Total	25.82%	26.24%	1.63%	NC
45–64 Years Subtotal Percentage—Total	15.35%	15.35%	0.00%	NC
65+ Years Subtotal Percentage—Total	2.20%	2.78%	26.36%	NC
Inpatient Utilization—General Hospital/Acute Care—Total[1]				
Maternity—Average Length of Stay—Total	2.57	2.32	-9.73%	NC
Maternity—Days per 1,000 Member Months—Total	5.27	5.39	2.28%	NC
Maternity—Discharges per 1,000 Member Months—Total	2.05	2.32	13.17%	NC
Medicine—Average Length of Stay—Total	4.80	4.37	-8.96%	NC
Medicine—Days per 1,000 Member Months—Total	9.73	8.35	-14.18%	NC
Medicine—Discharges per 1,000 Member Months—Total	2.03	1.91	-5.91%	NC
Surgery—Average Length of Stay—Total	6.71	8.85	31.89%	NC
Surgery—Days per 1,000 Member Months—Total	5.28	9.25	75.19%	NC
Surgery—Discharges per 1,000 Member Months—Total	0.79	1.04	31.65%	NC
Total Inpatient—Average Length of Stay—Total	4.43	4.70	6.09%	NC
Total Inpatient—Days per 1,000 Member Months—Total	18.55	21.22	14.39%	NC
Total Inpatient—Discharges per 1,000 Member Months—Total	4.19	4.52	7.88%	NC
Mental Health Utilization[2]				
Any Service—Total	—	8.24%	—	NC
Inpatient—Total	—	0.41%	—	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.10%	—	NC
Outpatient—Total	—	8.17%	—	NC
*ED—Total**	—	0.03%	—	NC
Telehealth—Total	—	0.09%	—	NC
Plan All-Cause Readmissions[1]				

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
*Index Total Stays—Observed Readmissions—Ages 18-44**	12.27%	12.45%	1.47%	★★★★
*Index Total Stays—Observed Readmissions—Ages 45-54**	12.93%	12.86%	-0.54%	★★★★
*Index Total Stays—Observed Readmissions—Ages 55-64**	13.40%	10.29%	-23.21%	★★★★★
*Index Total Stays—Observed Readmissions—Total**	12.80%	11.89%	-7.11%	★★★★

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 for HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, a relative difference could not be calculated, 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.
2019 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 63 measure rates comparable to benchmarks, 55 measure rates (87.3 percent) ranked at or above the 50th percentile, with 24 of these rates (38.1 percent) exceeding the 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met 12 of the MQD Quality Strategy targets for HEDIS 2019: *Childhood Immunization Status—Combination 3*; *Breast Cancer Screening*; *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)*; *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*; and *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*.

Conversely, eight of KFHP QI's measure rates comparable to benchmarks (12.7 percent) fell below the 50th percentile, with three of these rates (4.8 percent) falling below the 25th percentile, suggesting some opportunities for improvement exist. HSAG recommends that KFHP QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Access to Care

  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*
- Children's Preventive Health
  - *Adolescent Well-Care Visits*

Validation of Performance Improvement Projects

Findings

Getting Needed Care PIP

KFHP QI's focus for this PIP was to increase the rate of members seen within 21 days of the initial request for an initial routine outpatient behavioral health (BH) evaluation. Details of KFHP QI's intervention for the PIP are presented in Table 3-34 and in the narrative below.

Table 3-34—Intervention Testing for *Getting Needed Care* PIP

Intervention	Key Driver	Failure Mode	Conclusion
Outreach by Member Care Service Associates (MCSAs) to provide transportation options to members	Patient barriers	Lack of transportation	The health plan chose to *adapt* the intervention.

The health plan chose to test member outreach, which included offering transportation. After initial testing, the health plan learned that lack of transportation was not a barrier. The health plan continued telephone outreach and sent follow-up letters by certified mail to members who could not be reached by telephone. The health plan indicated plans to adapt the intervention; it will continue telephone outreach but will send the follow-up letter via regular first-class mail instead of certified mail.

The health plan concluded:

- Data illustrated that the outreach call was effective in positively impacting the SMART Aim measure for four of five months during the intervention testing period.
- Effectiveness of the letters was not demonstrated.
- Lack of transportation was not a significant barrier to completing evaluation appointments.

HSAG validated KFHP QI's *Getting Needed Care* PIP SMART Aim measure rates based on the results in Module 5. Table 3-35 below provides the level of confidence HSAG assigned to the PIP.

Table 3-35—SMART Aim Results for *Getting Needed Care* PIP

SMART Aim	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
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 BH evaluation by internal providers on Oahu from 50% to 55%.	73.0%	Yes	Yes	*Confidence*

The SMART Aim goal was exceeded for three of the four months while the intervention was tested. The health plan completed only four months of intervention testing prior to the SMART Aim end date, and the SMART Aim measure rate improved before the intervention began. Therefore, HSAG assigned the PIP a level of *Confidence*.

Medication Management for People with Asthma Ages 5–64 PIP

KFHP QI's focus for this PIP was to decrease the rate of members with an asthma medication ratio (AMR) of less than 0.5. Details of KFHP QI's intervention for the PIP are presented in Table 3-36 and in the narrative below.

Table 3-36—Intervention Testing for *Medication Management for People with Asthma, Ages 5–64* PIP

Intervention	Key Driver	Failure Mode	Conclusion
Clinical pharmacists assess members with home clinic locations in Honolulu, Waipio, and Maui Lani, ages 5–64, identified in December 2017 and reconfirmed in April 2018 with an AMR less than 0.5; outreach to members occurs if indicated by the assessment.	Member education	Unaware of when to use inhalers	The health plan chose to *adapt* the intervention.

The health plan tested the intervention from April 2018 through December 2018 and documented plans to adapt the intervention by providing outreach every three months instead of every month for clinically stable members who had an AMR less than 0.5. Additionally, fourth-year pharmacy students will complete the outreach.

The health plan concluded:

- Results of the intervention validated the predicted outcome of the test. The intervention effectiveness data illustrated an overall downward trend in the number of members in the initial cohort with AMRs less than 0.5 (defined in December 2017, validated in April 2018) from 47 to 30.

- The SMART Aim data further illustrated an overall decrease in the rate of members ages 5 to 64 years with AMRs less than 0.5 in the overall cohort, and home clinic locations in Honolulu, Waipio, and Maui Lani, meeting the target for six of the nine months.

HSAG validated KFHP QI's *Medication Management for People with Asthma, Ages 5–64* PIP SMART Aim measure rates based on the results in Module 5. Table 3-37 below provides the level of confidence HSAG assigned to the PIP.

Table 3-37—Status of the *Medication Management for People with Asthma, Ages 5–64* PIP

SMART Aim	Lowest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, decrease the rate of QUEST Integration members, ages 5–64 years old with home clinic locations in Honolulu, Waipio, and Maui Lani, with an AMR of less than 0.5 from 26.3% to 24.3%.	21.1%	Yes	Yes	*High Confidence*

The SMART Aim measure results demonstrated that the goal was exceeded for six months from July through December 2018 and that the intervention tested was clearly linked to the improvement; therefore, the PIP was assigned a level of *High Confidence*.

Strengths and Weaknesses

The validation findings suggest that KFHP QI was successful in executing the rapid-cycle PIPs. The PIPs were methodologically sound, achieved the SMART Aim measure goals, and linked the quality improvement processes and interventions to the demonstrated improvement. The *Getting Needed Care* PIP received a *Confidence* rating, and the *Medication Management for People with Asthma, Ages 5–64* PIP received a *High Confidence* rating.

KFHP QI identified the following key learnings from its two PIPs:

Getting Needed Care:

- The automated appointment reports proved to be a valuable investment. Using the report was a quicker, more proactive way of identifying members requiring outreach; tracking progress was simple; and adjustments to the frequency or the time frames could be made as needed. Challenges with staffing and communication were eliminated with the automation.
- Lack of transportation was found not to be a main barrier to accessing care but can continue to be part of the outreach reminder call intervention.
- The value of incorporating proactive processes in KFHP QI's approach to improving care can be as simple as a reminder call and still positively impact a member's ability to get needed care.

Medication Management for People with Asthma, Ages 5–64:

- Targeted outreach in the months of October and November would be beneficial to assure adequate asthma control throughout cold and flu season.
- Effectiveness of therapy can be dependent on the device the member is using due to the differences in technique with the delivery device. Follow-up with these members was key in assuring appropriate use of the device, answering any questions, and assessing for any nonadherence with the therapy.
- Outreach needs to be multifaceted using email and/or phone calls to target the most effective way to contact the member.
- Providing tips to members on ways to remember when to use the inhaler was helpful.

Recommendations for Improvement

- KFHP QI should ensure that interventions are started in a timely manner. If delays occur, the health plan may not have enough data points to clearly link interventions to improvement by the SMART Aim end date.
- KFHP QI should ensure complete and accurate documentation of results.
- KFHP QI should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Member Experience Analysis

Findings

Table 3-38 presents the 2019 percentage of top-box responses for KFHP QI compared to the 2018 NCQA child Medicaid national averages and the corresponding 2017 scores.[3-23,3-24,3-25] Additionally, the

[3-23] 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.
[3-24] The adult population was last surveyed in 2018; therefore, the 2019 child CAHPS scores are compared to the corresponding 2017 scores.
[3-25] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2018.

overall member experience ratings (i.e., star ratings) resulting from KFHP QI's top-box scores compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-26]

Table 3-38—Child Medicaid CAHPS Results *for* KFHP QI

Measure	2017 Scores	2019 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	73.9%	71.9%	★★★
Rating of All Health Care	70.0%	64.5%	★
Rating of Personal Doctor	80.0%	79.3%	★★★
Rating of Specialist Seen Most Often	72.0%+	74.7%+	★★★
Composite Measures			
Getting Needed Care	84.2%	81.5%	★
Getting Care Quickly	90.5%	90.4%	★★★
How Well Doctors Communicate	96.8%	96.2%	★★★★
Customer Service	92.5%	88.3%+	★★
Shared Decision Making	81.4%	79.6%+	★★★
Individual Item Measures			
Coordination of Care	89.9%	84.8%	★★★
Health Promotion and Education	76.1%	79.8%	★★★★★

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child Medicaid national averages.
▲ Indicates the 2019 score is statistically significantly higher than the 2017 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
+ 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

Strengths

For KFHP QI's child Medicaid population, the following eight measures met or exceeded the 2018 NCQA child Medicaid national averages:

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

[3-26] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Coordination of Care*
- *Health Promotion and Education*

In addition, one measure met or exceeded the 90th percentile, *Health Promotion and Education*. 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 experience rating for *How Well Doctors Communicate* met or exceeded the 75th percentile.

Areas for Improvement

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. 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 experience with each of the three measures; therefore, KFHP QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-39 provides a summary of the key drivers identified for KFHP QI.

Table 3-39—KFHP QI Key Drivers of Member Experience Analysis

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.	✓	✓	
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.		✓	✓
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.	✓		
Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.			✓
Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.	✓	✓	✓

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

- Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.
- Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.

The following observations from the key drivers of member experience analysis indicate areas for improvement in quality of care for KFHP QI:

- Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.
- Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.
- Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.

Overall Assessment of Quality, Access, and Timeliness of Care

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

Conclusions

In general, KFHP QI's performance results illustrate mixed performance across the four EQR activities. While the compliance monitoring review activity revealed that KFHP QI had yet to fully implement the revised managed care regulations released in 2016 and the need for operational changes to support the quality of, access to, and timeliness of care and service delivery, HEDIS measure results and PIP results indicate a high level of performance on outcome and process measures.

KFHP QI's performance during the 2019 compliance review was below average, meeting or exceeding the statewide compliance score for only one of the six standards. It did not score 100 percent in any of the standards, resulting in 33 elements requiring corrective action. KFHP QI performed strongest in the *Access and Availability* standard and the lowest in the *Member Rights and Protections* standard. KFHP QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor KFHP QI's CAP activities until the health plan is found to be in full compliance.

Overall, more than three-quarters (87.3 percent) of KFHP QI's measure rates ranked at or above the 50th percentile across all domains, with two-thirds (66.7 percent) of the measure rates ranking above the 75th percentile. Conversely, less than 5 percent of KFHP QI's measure rates fell below the 25th percentile.

KFHP QI's performance did demonstrate a few areas for improvement including the Access to Care and Behavioral Health domains. KFHP QI's measure rates met 12 of the 14 MQD Quality Strategy targets.

Conversely, KFHP QI's CAHPS results illustrate opportunities for improvement in members' experiences with care. While none of the measures scored statistically significantly lower in 2019 than in 2017, the following three measures were below the 50th percentiles and the 2018 NCQA child Medicaid national averages: *Rating of All Health Care*, *Getting Needed Care*, and *Customer Service*.

Finally, the results of KFHP QI's PIPs indicate that the health plan understands the rapid-cycle PIP process and has the ability to apply key quality improvement principles. Performance across the two PIPs was high, with the *Getting Needed Care* PIP being assessed with *Confidence* while the *Medication Management for People with Asthma Ages 5–64* PIP was assessed with *High Confidence.* Additionally, in 2019, KFHP QI submitted Module 1 and Module 2 for two new topics specified by the MQD (*Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness*) and, at the time of this report, was in the process of resubmitting Module 1 and Module 2 to achieve all validation criteria before progressing to Module 3.

While KFHP QI had strong performance on the outcome and process measures, the MCO scored below the statewide average and all other health plans on the compliance review, suggesting opportunities for improvement in health plan operations and implementation of managed care regulations. KFHP QI scored particularly low on the following member-focused compliance standards: *Coverage and Authorization of Services*, *Member Grievance System*, *Member Rights and Protections*, and *Member Information*, which may have impacted the CAHPS survey results. Since CAHPS survey measures assess members' perceptions, poor performance on the *Rating of All Health Care*, *Getting Needed Care*, and *Customer Service* measures indicates that members perceived barriers to accessing care and services and that the quality of care received from health plan providers did not always meet member expectations. Similarly, the MCO's HEDIS measure performance for *Children and Adolescents' Access to Primary Care Practitioners* and *Adolescent Well-Care Visits* indicates room for improvement in access to care for KFHP QI's adolescent members. The *Medication Management for People With Asthma* measures ranked below the 50th percentile; however, KFHP QI's *Medication Management for People with Asthma Ages 5–64* PIP was assessed with *High Confidence*, and the MCO should consider continued implementation of the interventions to improve these rates.

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

Compliance Monitoring Review

The 2019 compliance monitoring review activity included evaluation of the health plan’s compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-40 presents the standards and compliance scores for ‘Ohana QI.

Table 3-40—Standards and Compliance Scores—’Ohana QI

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	23	9	72%
II	Access and Availability	16	14	2	88%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Member Rights and Protections	9	8	1	89%
V	Member Information	22	17	5	77%
VI	Member Grievance System	27	18	9	67%
	Totals	**116**	**90**	**26**	**78%**

Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.

Strengths

‘Ohana QI was found to be 100 percent compliant with the Coordination and Continuity of Care standard. Through its policies, procedures, case presentation, and compliance review interview sessions, ‘Ohana QI demonstrated its capability to provide person-centered service to address members’ level of need. ‘Ohana QI staff described comprehensive procedures designed to direct, coordinate, monitor, and track the medical, behavioral health, and long-term care services needed by its members. The health plan’s documentation and interview responses outlined the procedures used to identify options for meeting the member’s healthcare needs and how staff facilitated access to medically necessary services while decreasing the fragmentation and duplication of care. ‘Ohana QI contracted with and provided a full range of medical, behavioral, and community-based services to ensure members received needed services that were provided in the most appropriate, least restrictive manner and setting.

The health plan also scored high with the Member Rights and Protections standard with 89 percent compliance, with only one element scoring a *Not Met.* ‘Ohana QI had policies, procedures, and written member and provider information regarding member rights. The health plan ensured that member rights

were protected by educating staff via trainings and monitoring call center staff members to evaluate adherence to member rights. ‘Ohana also reviewed member grievances related to violations of rights, which provided an opportunity to identify and retrain staff and providers on member rights. In addition, ‘Ohana disseminated information to members, providers, and employees regarding nondiscrimination policies and the applicable federal and State laws.

‘Ohana QI was found to be 88 percent compliant with the *Access and Availability* standard, with two elements scoring a *Not Met.* ‘Ohana QI had systems, policies, processes, and organizational structure in place to regularly evaluate and monitor access to and availability of its services and network providers for enrolled members. In addition to policies, ‘Ohana QI staff discussed the mechanisms used to measure both geographic accessibility (by time and distance) and timeliness of appointments during the on-site compliance review. ‘Ohana QI used GeoAccess reporting/analysis and a network adequacy tool to evaluate its network and generate reports showing any gaps in the network as measured by the distance from the members’ residence to the nearest physical health provider, BH provider, or specialist. ‘Ohana QI also conducted quarterly member and provider surveys to determine provider availability for appointments and member satisfaction regarding timely access to appointments.

Areas for Improvement

‘Ohana QI was found to be 77 percent compliant with the Member Information standard, with five elements scoring a *Not Met.* ‘Ohana QI had member information, call center staff members, and service coordinators available to help members understand the requirements and benefits of the plan. The health plan had processes in place to ensure member information on the health plan website was readily accessible. The corrective actions required by ‘Ohana QI were related to policy and procedure updates, member handbook updates to ensure correct information was provided to members, and provider directory updates to ensure all required elements were included.

‘Ohana QI was found to be compliant with 72 percent of the Coverage and Authorization of Services standard, with nine elements scoring a *Not Met.* While ‘Ohana QI provided documented policies. procedures, and program descriptions of its UM program, the completeness and quality of that documentation was inconsistent across ‘Ohana lines of business (i.e., QI versus CCS) and between operational policies and procedures and member/provider materials. In some cases, documentation did not incorporate the most recent requirements contained in the 2016 Final Medicaid Managed Care rules. In addition, timelines outlined in the CFRs for the reduction, suspension, and termination of authorizations were not followed by ‘Ohana QI. The corrective actions required by ‘Ohana QI included policy and procedure updates to align with current CFRs and State requirements as well as member notification letter template updates to include all required information.

‘Ohana QI was found to be compliant with 67 percent of the Member Grievance System standard, with nine elements scoring a *Not Met.* While ‘Ohana QI had comprehensive policies and procedures for the processing of grievances and appeals, some definitions, time frames, and procedures did not align with current federal regulations and State contracts. The corrective actions required by ‘Ohana QI were related to updating policies, procedures, member notification letter templates, and provider information to be in compliance with federal and State regulations. In addition, ‘Ohana QI was required to

implement standardized processes for ensuring member notification letters were written at or below a sixth-grade reading level.

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 six standard and three nonstandard supplemental data sources for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2019 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 ensure appropriate Roadmap documentation for all supplemental data sources going forward.

All QI measures which 'Ohana QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted. For 'Ohana QI reporting, the *Cardiovascular Monitoring for People with Cardiovascular Disease* and *Schizophrenia, Follow-Up After Emergency Department Visit for Mental Illness*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*, *Follow-Up After Hospitalization for Mental Illness, Follow-Up Care for Children Prescribed ADHD Medication, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment,* and *Medication Management for People with Asthma* measure indicators received a designation of *Small Denominator* (NA).

'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—*Controlling High Blood Pressure*
- Group B: Anticipatory Guidance & Counseling—*Adolescent Well-Care Visits*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- Group D: Immunization & Other Screenings—*Immunizations and Other Screenings: CIS-Combo 3*
- Group F: Exclusions—All Medical Record Exclusions

Access to Care Performance Measure Results

'Ohana QI's Access to Care performance measure results are shown in Table 3-41. One measure rate ranked at or above the 50th percentile. Conversely, eight of the remaining nine measure rates fell below

the 25th percentile. Two of the rates in this domain reported a relative decline of more than 10 percent in HEDIS 2019. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2019.

Table 3-41—'Ohana QI's HEDIS Results for QI Measures Under Access to Care

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adults' Access to Preventive/Ambulatory Health Services[1]				
20–44 Years	59.33%	59.44%	0.19%	★
45–64 Years	78.70%	79.25%	0.70%	★
65 Years and Older	89.32%	88.81%	-0.57%	★★★
Total	72.57%	72.97%	0.55%	★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	91.27%	92.74%	1.61%	★
25 Months–6 Years	77.87%	76.10%	-2.27%	★
7–11 Years	80.78%	81.40%	0.77%	★
12–19 Years	77.05%	79.59%	3.30%	★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	48.42%	35.12%	-27.47%	★
Engagement of AOD Treatment—Total	15.04%	10.64%	-29.26%	★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.*

2019 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 3-42. Eight rates in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, four measure rates ranked at or above the 50th percentile. Conversely, 15 measure rates fell below the 25th percentile. One measure rate in this domain demonstrated a relative decline of more than 10 percent in HEDIS 2019. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2019 (i.e., *Childhood Immunization Status—Combination 3*), and 'Ohana QI did not reach the established target, the 75th percentile.

Table 3-42—'Ohana QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	39.17%	49.15%	25.48%	★★
Childhood Immunization Status[1]				
Combination 3	55.12%	50.16%	-9.00%	★
DTaP	61.75%	58.26%	-5.65%	★
Hepatitis B	71.08%	73.83%	3.87%	★
HiB	73.80%	78.19%	5.95%	★
IPV	71.39%	74.14%	3.85%	★
MMR	76.51%	77.57%	1.39%	★
Pneumococcal Conjugate	62.05%	58.26%	-6.11%	★
VZV	75.90%	74.77%	-1.49%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	34.83%	48.28%	38.62%	★
Combination 2 (Meningococcal, Tdap, HPV)	11.61%	18.62%	60.38%	★
HPV	14.98%	22.07%	47.33%	★
Meningococcal	40.82%	53.10%	30.08%	★
Tdap	38.95%	52.76%	35.46%	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	1.90%	3.88%	104.21%	★
Six or More Well-Child Visits	65.08%	67.31%	3.43%	★★★
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	65.51%	62.23%	-5.01%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	72.93%	79.56%	9.09%	★★★
Counseling for Nutrition—Total	62.93%	75.67%	20.24%	★★★
Counseling for Physical Activity—Total	50.73%	70.56%	39.09%	★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
2019 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 3-43. Four rates in this domain reported a relative decline of more than 10 percent in HEDIS 2019, and all seven measure rates fell below the 25th percentile. Three measures[3-27] in this domain had an MQD Quality Strategy target for HEDIS 2019. None of 'Ohana QI's measure rates met or exceeded the established MQD Quality Strategy targets.

Table 3-43—'Ohana QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Breast Cancer Screening[1]				
Breast Cancer Screening	52.07%	51.35%	-1.38%	★
Cervical Cancer Screening				
Cervical Cancer Screening	51.82%	45.26%	-12.66%	★
Chlamydia Screening in Women				
16–20 Years	39.13%	27.88%	-28.75%	★
21–24 Years	54.62%	44.63%	-18.29%	★
Total	49.25%	37.84%	-23.17%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	71.53%	75.62%	5.72%	★
Postpartum Care	46.72%	48.77%	4.39%	★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
2019 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 3-44. Two rates in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Four measure rates ranked at or above the 75th percentile, with one of these rates exceeding the 90th percentile. Seven measures[3-28] within this domain were associated with an MQD Quality Strategy target

[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*.
[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)..

for HEDIS 2019, with ‘Ohana QI meeting or exceeding the target for two measures, both related to *Comprehensive Diabetes Care*.

Table 3-44—‘Ohana QI’s HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	91.63%	92.35%	0.79%	★★★★
Diuretics	92.15%	93.01%	0.93%	★★★★★
Total	91.80%	92.55%	0.82%	★★★★
Comprehensive Diabetes Care[1]				
HbA1c Testing	85.90%	88.08%	2.54%	★★★
*HbA1c Poor Control (>9.0%)**	46.44%	39.66%	-14.60%	★★
HbA1c Control (<8.0%)	44.04%	51.58%	17.12%	★★★
Eye Exam (Retinal) Performed	64.24%	65.45%	1.88%	★★★★
Medical Attention for Nephropathy	89.68%	91.48%	2.01%	★★★
Blood Pressure Control (<140/90 mm Hg)	59.23%	63.02%	6.40%	★★★
Controlling High Blood Pressure[2]				
Controlling High Blood Pressure	—	62.53%	—	NC
Medication Management for People With Asthma[1]				
Medication Compliance 50%—Total	69.91%	63.21%	-9.58%	★★★
Medication Compliance 75%—Total	46.46%	42.45%	-8.63%	★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years’ 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.
2019 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

‘Ohana QI’s Behavioral Health performance measure results are shown in Table 3-45. Two measures in this domain had an MQD Quality Strategy target for HEDIS 2019, and ‘Ohana QI did not meet either of the established targets, the 75th percentile.

Three of the nine reportable measure rates ranked at or above the 50th percentile. Conversely, five rates in this domain demonstrated a relative decline of more than 10 percent in HEDIS 2019, and six measure rates fell below the 50th percentile, with three of these rates falling below the 25th percentile. Two measures[3-29] in this domain had an MQD Quality Strategy target for HEDIS 2019, and 'Ohana QI did not meet either of the established targets, the 75th percentile.

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

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	51.26%	48.22%	-5.93%	★
Effective Continuation Phase Treatment	34.71%	36.76%	5.91%	★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia[1]				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	—	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[1]				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	71.14%	73.24%	2.95%	★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7 Day Follow-Up—13–17 Years	NA	NA	—	NC
7 Day Follow-Up—18+ Years	10.86%	9.06%	-16.57%	★★
7 Day Follow-Up—Total	10.68%	8.90%	-16.67%	★★
30 Day Follow-Up—13–17 Years	NA	NA	—	NC
30 Day Follow-Up—18+ Years	17.74%	18.73%	5.58%	★★★
30 Day Follow-Up—Total	17.43%	18.40%	5.57%	★★★
Follow-Up After ED Visit for Mental Illness[2]				
7-Day Follow-Up—Total	—	22.71%	—	NC
30-Day Follow-Up—Total	—	39.44%	—	NC
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—Total	38.60%	33.83%	-12.36%	★★
30-Day Follow-Up—Total	57.21%	48.76%	-14.77%	★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	—	NC
Continuation and Maintenance Phase	NA	NA	—	NC

[3-29] Within this domain, there were two MQD Quality Strategy targets: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total.*

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness				
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	55.72%	44.38%	-20.35%	NC

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 3-46. Excluding *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total, ED Visits for Ambulatory Care Sensitive Conditions*, 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 *Plan All-Cause Readmissions*, all four measure rates fell below the 25th percentile, and three of these measure rates demonstrated a relative increase of more than 10 percent in HEDIS 2019, indicating worse performance. Neither of the *ED Visits for Ambulatory Care Sensitive Conditions* measure rates demonstrated a relative improvement or decrease of more than 10 percent in HEDIS 2019. The *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure failed to meet the MQD Quality Strategy target for HEDIS 2019, the 90th percentile.

Table 3-46—'Ohana QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	62.71	62.41	-0.48%	★★
Outpatient Visits—Total[1]	570.59	426.68	-25.22%	NC
ED Visits for Ambulatory Care Sensitive Conditions*				
PCP Treatable ED Visits	13.28%	14.43%	8.67%	NC

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Preventable/Avoidable ED Visits	64.70%	64.23%	-0.72%	NC
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	23.91%	25.86%	8.16%	NC
20–44 Years Subtotal Percentage—Total	34.22%	33.24%	-2.86%	NC
45–64 Years Subtotal Percentage—Total	27.92%	27.24%	-2.44%	NC
65+ Years Subtotal Percentage—Total	13.95%	13.66%	-2.08%	NC
Inpatient Utilization—General Hospital/Acute Care—Total[1]				
Maternity—Average Length of Stay—Total	2.70	2.56	-5.19%	NC
Maternity—Days per 1,000 Member Months—Total	5.37	5.26	-2.05%	NC
Maternity—Discharges per 1,000 Member Months—Total	1.99	2.06	3.52%	NC
Medicine—Average Length of Stay—Total	6.61	5.74	-13.16%	NC
Medicine—Days per 1,000 Member Months—Total	53.75	44.26	-17.66%	NC
Medicine—Discharges per 1,000 Member Months—Total	8.13	7.71	-5.17%	NC
Surgery—Average Length of Stay—Total	9.93	13.41	35.05%	NC
Surgery—Days per 1,000 Member Months—Total	33.75	40.27	19.32%	NC
Surgery—Discharges per 1,000 Member Months—Total	3.40	3.00	-11.76%	NC
Total Inpatient—Average Length of Stay—Total	7.05	7.25	2.84%	NC
Total Inpatient—Days per 1,000 Member Months—Total	91.41	88.29	-3.41%	NC
Total Inpatient—Discharges per 1,000 Member Months—Total	12.97	12.18	-6.09%	NC
Mental Health Utilization[2]				
Any Service—Total	—	13.86%	—	NC
Inpatient—Total	—	0.96%	—	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.66%	—	NC
Outpatient—Total	—	13.31%	—	NC
*ED—Total**	—	0.71%	—	NC
Telehealth—Total	—	0.16%	—	NC
Plan All-Cause Readmissions[1]				

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
*Index Total Stays—Observed Readmissions—Ages 18–44**	18.03%	21.79%	20.85%	★
*Index Total Stays—Observed Readmissions—Ages 45–54**	18.50%	19.07%	3.08%	★
*Index Total Stays—Observed Readmissions—Ages 55–64**	17.05%	18.97%	11.26%	★
*Index Total Stays—Observed Readmissions—Total**	17.73%	19.82%	11.79%	★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 62 measure rates comparable to benchmarks, only 18 measure rates (29.0 percent) ranked at or above the 50th percentile, with four of these rates (6.5 percent) ranking above the 75th percentile, indicating positive performance in eye care for members with diabetes, and monitoring of members on persistent medications. Additionally, 'Ohana QI met two of the MQD Quality Strategy targets for HEDIS 2019: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Eye Exam (Retinal) Performed*.

Conversely, 44 of 'Ohana QI's measure rates comparable to benchmarks (71.0 percent) fell below the 50th percentile, with 37 of these rates (59.7 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains. HSAG recommends that 'Ohana QI focus on improving performance related to the following measures with rates that fell below the 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*

  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
- 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)*, *Combination 2 (Meningococcal, Tdap, HPV)*, *HPV*, *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
  - *Breast Cancer Screening*
  - *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*
- Behavioral Health
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- Utilization and Health Plan Descriptive Information
  - *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Ages 18–44*, *Ages 45–54*, *Ages 55–64*, and *Total*

Validation of Performance Improvement Projects

Findings

Getting Needed Care PIP

'Ohana QI's focus for this PIP was to increase the percentage of members who responded positively on a survey regarding the ability to schedule an appointment for a check-up or routine care at a specialist as soon as needed. Details of 'Ohana QI's intervention for the PIP are presented in Table 3-47 and in the narrative below.

Table 3-47—Intervention Testing for *Getting Needed Care* PIP

Intervention	Key Driver	Failure Mode	Conclusion
Care gap coordinator(s)/patient care advocate(s) outreach members, locate and schedule appointment with a provider.	Member behavior	Members cannot locate a provider for their condition.	The health plan chose to *abandon* the intervention.

The health plan tested one intervention to outreach members and help them locate and schedule appointments with a provider from April 2018 through December 2018.

The health plan concluded:

- The intervention was not effective.

HSAG validated 'Ohana QI's *Getting Needed Care* PIP SMART Aim measure rates based on the results in Module 5. Table 3-48 provides the level of confidence HSAG assigned to the PIP.

Table 3-48—SMART Aim Results for *Getting Needed Care* PIP

SMART Aim	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, increase responses set as "Always" or "Usually" from 82.2% to 87.2% for the Getting Needed Care domain.	68.9%	No	Not Applicable	*Low Confidence*

Based on the intervention data, the health plan determined that the intervention was not effective, and the health plan did not meet the SMART Aim goal. HSAG assigned the PIP a level of *Low Confidence*.

Improving Timeliness of Prenatal and Postpartum Care PIP

'Ohana QI's focus for this PIP was to increase the rate of members receiving timely prenatal care and postpartum care appointments. Details of 'Ohana QI's intervention for the PIP are presented in Table 3-49 and in the narrative below.

Table 3-49—Intervention Testing for *Improving Timeliness of Prenatal and Postpartum Care* PIP

Intervention	Key Drivers	Failure Modes	Conclusion
Care gap coordinators and/or patient care advocates to assist providers with scheduling member appointments, providing an online portal for navigation, transportation, and translation services through telephonic member outreach.	Provider lack of engagement—lack of tracking whether or not the member completed the visit and outreaching; lack of provider's resources to follow up on members.	• Prenatal: Provider does not schedule a woman's prenatal visit in a timely manner, within the first trimester. • Postpartum: Provider does not schedule a woman's postpartum visit in a timely manner, between 21 and 56 days after delivery.	The health plan chose to *continue testing* the intervention.

For both prenatal and postpartum care, the health plan tested use of care gap coordinators and/or patient care advocates to assist providers with scheduling member appointments and to provide an online portal for navigation, transportation, and translation services through telephonic member outreach. The health plan tested the intervention from April 2018 to December 2018.

The health plan concluded:

- There were several changes to the organization and structure of the Care Gap Coordination Program during the year, which may have contributed to effectiveness of the intervention.
- While the number of successful member outreaches appeared low, further testing can be done since there were changes to the Care Gap Coordination Program's structure and assignments.

HSAG validated 'Ohana QI's *Improving Timeliness of Prenatal and Postpartum Care* PIP SMART Aim measure rates based on the results in Module 5. Table 3-50 below provides the level of confidence HSAG assigned to the PIP.

Table 3-50—Status of the *Improving Timeliness of Prenatal and Postpartum Care* PIP

SMART Aim	Measure	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, 'Ohana Health Plan 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.	Prenatal	65.8%	No	Not Applicable	*Low Confidence*
By December 31, 2018, 'Ohana Health Plan aims to increase the timeliness of postpartum care from 37% to 47% for members who delivered and reside in Honolulu, Waianae, Waipahu, Kailua Kona, Hilo, and Ewa Beach.	Postpartum	31.9%	No	Not Applicable	

Based on the intervention data, it appears that the health plan was able to outreach very few members. Issues leading to low outreach included staffing, inability to contact members, and inaccurate or untimely data on member pregnancy/enrollment status. None of the SMART Aim measure results achieved the SMART Aim goal. Therefore, HSAG assigned the PIP a level of *Low Confidence*.

Strengths and Weaknesses

The validation results suggest that ‘Ohana QI’s tested interventions were not successful in achieving the goals for the PIPs. None of the SMART Aim measure results achieved the SMART Aim goals. HSAG assigned a level of *Low Confidence* to both PIPs.

‘Ohana QI identified the following key learnings from its two PIPs:

Getting Needed Care:

- The health plan should consider resources needed for the project and plan appropriately by considering the tools, systems, and training.
- The health plan’s member-facing teams used different tools for their regular daily outreaches, which made it difficult to track and monitor all the outreaches conducted. Therefore, a Microsoft SharePoint tool was developed to collect the survey results, but it only collected results from those who responded to the survey.
- It is important to have health plan leadership emphasize the importance of PIPs and ensure managers/supervisors of other teams are involved and can help address any barriers to achieving the goal.

Improving Timeliness of Prenatal and Postpartum Care:

- The health plan should consider resources needed for the project (including staff resources) and plan appropriately by considering the tools, systems, and training. Only one care gap coordinator was assigned to the project.
- One of the biggest barriers is being unable to contact members. The unable to contact rate is approximately 50 percent for PIPs. The health plan should consider how to handle members who cannot be reached.
- The health plan should ensure the data are received in a timely manner and that the care gap coordinator is calling the member as soon as possible to schedule prenatal care.
- More frequent education and training is needed for team members and managers/supervisors who work on a PIP about the PIP’s importance so they can ensure full support and help address any barriers to achieving the goal.

Recommendations for Improvement

- ‘Ohana QI should ensure that it documents complete and correct results in the PIP submissions and that rates are reported in alignment with the approved methodology.
- ‘Ohana QI should continue to look for ways to obtain accurate member contact information and correct any staffing and data issues that may impact members receiving timely care.
- ‘Ohana QI should ensure that interventions are started in a timely manner. If delays occur, the health plan may not incur enough data points by the SMART Aim end date.

- 'Ohana QI should apply the lessons learned and knowledge gained to future PIPs and quality improvement activities.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Member Experience Analysis

Findings

Table 3-51 presents the 2019 percentage of top-box responses for 'Ohana QI compared to the 2018 NCQA child Medicaid national averages and the corresponding 2017 scores.[3-30,3-31,3-32] Additionally, the overall member experience ratings (i.e., star ratings) resulting from 'Ohana QI's top-box scores compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-33]

Table 3-51—Child Medicaid CAHPS Results *for* 'Ohana QI

Measure	2017 Scores	2019 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	60.4%	65.2%	★
Rating of All Health Care	59.7%	61.3%	★
Rating of Personal Doctor	68.0%	74.8%	★★
Rating of Specialist Seen Most Often	73.2%+	76.3%+	★★★
Composite Measures			
Getting Needed Care	77.6%	79.1%	★
Getting Care Quickly	81.5%	79.6%	★

[3-30] 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.
[3-31] The adult population was last surveyed in 2018; therefore, the 2019 child CAHPS scores are compared to the corresponding 2017 scores.
[3-32] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2018.
[3-33] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

Measure	2017 Scores	2019 Scores	Star Ratings
How Well Doctors Communicate	93.0%	91.8%	★
Customer Service	80.3%	80.2%	★
Shared Decision Making	85.8%+	80.9%+	★★★
Individual Item Measures			
Coordination of Care	77.8%	88.6%+ ▲	★★★★★
Health Promotion and Education	76.6%	81.1%	★★★★★

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child Medicaid national averages.
▲ Indicates the 2019 score is statistically significantly higher than the 2017 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
+ 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

Strengths

For ‘Ohana QI’s child Medicaid population, the following four measures met or exceeded the 2018 NCQA child Medicaid national averages:

- *Rating of Specialist Seen Most Often*
- *Shared Decision Making*
- *Coordination of Care*
- *Health Promotion and Education*

In addition, one measure scored statistically significantly higher in 2019 than in 2017, *Coordination of Care*.

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

- *Coordination of Care*
- *Health Promotion and Education*

None of the three MQD beneficiary satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—met or exceeded the 75th percentile for ‘Ohana QI.

Areas for Improvement

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. 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 experience with each of the three measures; therefore, 'Ohana QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-52 provides a summary of the key drivers identified for 'Ohana QI.

Table 3-52—'Ohana QI Key Drivers of Member Experience Analysis

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that when their child needed care right away, they did not receive care as soon as they needed it.	✓	✓	
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.			✓
Respondents reported that their child's personal doctor did not always spend enough time with them.	✓		✓
Respondents reported that it was often not easy for their child to obtain appointments with specialists.	✓		
Respondents reported that they did not always receive the information or help they needed from customer service at their child's health plan.	✓	✓	
Respondents reported that they did not always receive courtesy and respect from customer service staff at their child's health plan.		✓	
Respondents reported that forms from their child's health plan were often not easy to fill out.	✓	✓	

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

- Respondents reported that when their child needed care right away, they did not receive care as soon as they needed it.
- Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.
- Respondents reported that it was often not easy for their child to obtain appointments with specialists.

The following observations from the key drivers of member experience analysis indicate areas for improvement in quality of care for 'Ohana QI:

- Respondents reported that their child's personal doctor did not always spend enough time with them.
- Respondents reported that they did not always receive the information or help they needed from customer service at their child's health plan.
- Respondents reported that they did not always receive courtesy and respect from customer service staff at their child's health plan.
- Respondents reported that forms from their child's health plan were often not easy to fill out.

Overall Assessment of Quality, Access, and Timeliness of Care

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

Conclusions

In general, 'Ohana QI's performance results illustrate mixed performance across the four EQR activities. While the compliance monitoring review activity revealed that 'Ohana QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, 'Ohana QI had yet to fully implement the revised managed care regulations released in 2016. In addition, performance on outcome and process measures showed considerable room for improvement.

'Ohana QI's performance during the 2019 compliance review was average, meeting or exceeding the statewide compliance score for three of the six standards. 'Ohana QI performed strongest in the *Coordination and Continuity of Care* standard with 100 percent compliance and lowest in the *Member Grievance System* standard with 67 percent compliance. 'Ohana QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana QI's CAP activities until the health plan is found to be in full compliance.

Overall, about three-quarters (71.0 percent) of 'Ohana QI's measures fell below the 50th percentile across all domains, with 59.7 percent of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS 2018, 'Ohana QI's performance demonstrated the need to improve process and outcome measures across all domains. In particular, 'Ohana QI should address performance in the Access to Care, Children's Preventive Health, Women's Health, and Utilization and Health Plan Descriptive Information domains where more than 75 percent of the measure rates were below the 50th percentile. Overall, only two of the MQD's 14 Quality Strategy targets were met in HEDIS 2019: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Eye Exam (Retinal) Performed*.

Similarly, 'Ohana QI's CAHPS results illustrate opportunities for improvement in members' experiences with care. While none of the measures scored statistically significantly lower in 2019 than in 2017, the following seven measures were below the 50th percentiles and the 2018 NCQA child Medicaid national averages: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal*

Doctor, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

Finally, the results of 'Ohana QI's PIPs indicate a need for ongoing quality improvement training of staff. HSAG assessed 'Ohana QI's *Getting Needed Care* and *Improving Timeliness of Prenatal and Postpartum Care* PIPs both as *Low Confidence.* The validation findings determined that the SMART Aim goals for both PIPs were not met. These results suggest that 'Ohana QI continues to have opportunities for improvement in executing the rapid-cycle PIP process. Additionally, in 2019, 'Ohana QI submitted Module 1 and Module 2 for two new PIP topics specified by the MQD (*Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness)* and, at the time of this report, was in the process of resubmitting Module 1 and Module 2 to achieve all validation criteria before progressing to Module 3.

'Ohana QI's performance on the *Coordination and Continuity of Care* compliance standard was strong and may also be supported by the MCO's CAHPS performance in care coordination and health promotion, for which both measures rated at or above Medicaid national averages. Conversely, while the compliance findings suggest 'Ohana QI's strength related to the *Access and Availability* standard, the MCO's HEDIS measure performance in the Access to Care domain, coupled with the less-than-average CAHPS performance on access to care-related measures, suggest opportunities for improvement in the access to care domain overall for 'Ohana QI. This is further supported by 'Ohana QI's performance on the *Getting Needed Care* and *Improving Timeliness of Prenatal and Postpartum Care* PIPs*,* where both PIPs failed to reach the SMART Aim goals. Since CAHPS survey measures assess members' perceptions, poor performance on the *Getting Needed Care* and *Getting Care Quickly* measures indicates that members perceive barriers when accessing care. These perceptions may be confirmed when access-related measures, such as *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services*, fail to meet the national average. 'Ohana QI would benefit from applying the QI tools and techniques learned from the rapid-cycle PIP process to identify and overcome the root cause for its subpar performance in the access to care domain.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

Compliance Monitoring Review

The 2019 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-53 presents the standards and compliance scores for UHC CP QI.

Table 3-53—Standards and Compliance Scores—UHC CP QI

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	28	4	88%
II	Access and Availability	16	16	0	100%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Member Rights and Protections	9	8	1	89%
V	Member Information	22	16	6	73%
VI	Member Grievance System	27	21	6	78%
	Totals	**116**	**99**	**17**	**85%**

Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.

Strengths

UHC CP QI was found to be 100 percent compliant with the *Access and Availability* standard. The health plan had the structure, systems, policies, and processes to regularly evaluate and monitor access to and availability of services and network providers for enrolled members. UHC CP QI's policies described the processes used to ensure that all covered services are available and accessible to members in a timely manner and outlined UHC CP QI's network infrastructure and how it aligned with federal and State regulations. The health plan's policies and procedures defined its access and availability standards and the mechanisms to monitor performance and identified methods to acknowledge high-performing providers and how to correct poor performance. All network data was monitored by staff, reviewed in key committees, and used to assess the ongoing health of UHC CP's provider network and compliance with federal and State regulations.

The health plan was also found to be 100 percent compliant with the Coordination and Continuity of Care standard. UHC CP QI had service coordination systems and processes in place to assess, plan, implement, coordinate, and monitor care provided to members through the health plan's service

coordination and case management programs. The health plan implemented a member-centric approach that focused on identifying the right member at the right time in order to ensure its members received the right interventions from the right resources. The health plan's comprehensive policies and procedures outlined UHC CP QI's approach to coordinating member benefits across all care settings. Service coordinators worked closely with members' PCPs, specialty physicians, therapists, and other health and social service providers to coordinate covered services, avoid duplication of services, communicate information among all involved, facilitate access to services, and actively manage transitions of care.

UHC CP QI was found to be 89 percent compliant with the Member Rights and Protections standard, with only one element scoring a *Not Met.* UHC CP QI had comprehensive policies, procedures, and written member and provider information regarding member rights. The health plan ensured that providers took member rights into account when furnishing services by monitoring member and provider survey results and grievances and appeals, disseminating member rights information via the provider manual and provider newsletters. UHC CP QI ensured that employees took member rights into account via member rights trainings, monitoring member grievances and appeals reports, promoting a culture of openness, integrity, continuous improvement, and community service. In addition, UHC CP QI disseminated information to members, providers, and employees regarding nondiscrimination policies and the applicable federal and State laws.

Areas for Improvement

UHC CP QI was found to be compliant with 88 percent of the Coverage and Authorization of Services standard, with four elements scoring a *Not Met.* UHC CP QI demonstrated consistency across its policies, procedures, member and provider materials, and interview responses during the on-site compliance review when describing how health plan staff manage benefit requests, issue coverage/authorization determinations, and communicate those decisions to members and providers. The corrective actions required by UHC CP QI were related to updating policies and procedures to include a description of the process used specifically for LTSS authorizations, updating processes to ensure timeliness of authorization decisions, and updating member notification letter templates to include all required language.

UHC CP QI was found to be compliant with 78 percent of the Member Grievance System standard, with six elements scoring a *Not Met.* While UHC CP QI had comprehensive policies and procedures for the processing of grievances and appeals, some of the processes and time frames used by the health plan were not in alignment with the current federal regulations and State contracts. The corrective actions required by UHC CP QI were related to updating policies, procedures, member notification letter templates, and provider information to be in compliance with federal and State regulations.

UHC CP QI was found to be 73 percent compliant with the Member Information standard, with six elements scoring a *Not Met.* In general, UHC CP QI had member information, call center staff members, and service coordinators available to help members understand the requirements and benefits of the plan. The corrective actions required by UHC CP QI were related to member handbook updates to ensure correct information was provided to members, provider directory updates, and implementing

processes to evaluate member documents on the health plan's website to ensure information was readily accessible to all members.

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 except IS 5.0, which was *Partially Compliant*. 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 eight standard and six nonstandard supplemental data sources for its performance measure reporting. A concern was identified for one of the standard databases and was not approved for use for HEDIS 2019. A concern was also identified for one of the nonstandard databases, but UHC CP QI was able to remove the erroneous records and use the data source. No other concerns were identified, and these data sources were approved for HEDIS 2019 measure reporting. All convenience samples passed HSAG's review.

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

- HSAG recommended that UHC CP QI improve their oversight process for supplemental data sources and ensure that measure specifications and general guidelines are followed specific to telehealth services and supplemental data obtained from electronic health record (EHR) data aggregators.

All QI measures which UHC CP QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted. For UHC CP QI reporting, the *Follow-Up After Emergency Department Visit for Mental Illness*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*, *Follow-Up After Hospitalization for Mental Illness,* and *Follow-Up Care for Children Prescribed ADHD Medication* measure indicators received a designation of *Small Denominator* (NA).

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*
- Group B: Anticipatory Guidance & Counseling—*Adolescent Well-Care Visits*
- Group C: Laboratory—Laboratory: *Cervical Cancer Screening (CCS)* and *Comprehensive Diabetes Care (CDC)—Medical Attention for Nephropathy*
- Group D: Immunization & Other Screenings—*CIS—Combo 3*
- 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 3-54. One measure rate in this domain exceeded the 90th percentile. Conversely, nine measure rates fell below the 50th percentile, with seven of these measure rates falling below the 25th percentile. Additionally, two rates in this domain reported a relative decline of more than 10 percent in HEDIS 2019. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2019.

Table 3-54—UHC CP QI's HEDIS Results for QI Measures Under Access to Care

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adults' Access to Preventive/Ambulatory Health Services[1]				
20–44 Years	57.68%	57.74%	0.10%	★
45–64 Years	79.40%	79.23%	-0.21%	★
65 Years and Older	94.77%	94.79%	0.02%	★★★★★
Total	76.83%	76.62%	-0.27%	★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	93.61%	93.21%	-0.43%	★
25 Months–6 Years	78.90%	77.36%	-1.95%	★
7–11 Years	80.89%	81.01%	0.15%	★
12–19 Years	79.08%	80.00%	1.16%	★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	38.62%	33.37%	-13.59%	★
Engagement of AOD Treatment—Total	11.38%	9.18%	-19.33%	★★

[1] *Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.*

2019 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 3-55. Four rates in this domain reported a relative improvement of more than 10 percent in HEDIS 2019. Additionally, five measure rates ranked at or above 50th percentile, with one of these rates ranking at or above the 75th percentile. Conversely, 15 measure rates fell below the 50th percentile, with 14 of these rates falling below the 25th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2019 (i.e., *Childhood Immunization Status—Combination 3*), and UHC CP QI did not reach the established target, the 75th percentile.

Table 3-55—UHC CP QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	45.74%	44.28%	-3.19%	★
Childhood Immunization Status[1]				
Combination 3	60.22%	63.07%	4.73%	★
DTaP	67.51%	68.09%	0.86%	★
Hepatitis B	82.07%	81.16%	-1.11%	★
HiB	83.47%	80.40%	-3.68%	★
IPV	80.95%	80.40%	-0.68%	★
MMR	78.99%	81.91%	3.70%	★
Pneumococcal Conjugate	67.23%	68.09%	1.28%	★
VZV	78.71%	80.90%	2.78%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	49.15%	54.60%	11.09%	★
Combination 2 (Meningococcal, Tdap, HPV)	20.09%	26.07%	29.77%	★
HPV	23.50%	29.14%	24.00%	★★
Meningococcal	54.27%	59.20%	9.08%	★
Tdap	54.70%	59.20%	8.23%	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	3.50%	1.44%	-58.86%	★★★
Six or More Well-Child Visits	70.70%	72.70%	2.83%	★★★★
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	61.12%	61.99%	1.42%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	83.29%	79.64%	-4.38%	★★★
Counseling for Nutrition—Total	69.83%	73.45%	5.18%	★★★
Counseling for Physical Activity—Total	62.59%	68.56%	9.54%	★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
2019 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 3-56. Two rates in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, one measure rate ranked at or above the 50th percentile. Conversely, six measure rates fell below the 50th percentile, with four of these rates falling below the 25th percentile. Two rates in this domain demonstrated a relative decline of more than 10 percent in HEDIS 2019. There were three measures[3-34] in this domain with MQD Quality Strategy targets for HEDIS 2019. None of UHC CP QI's measure rates met or exceeded the established MQD Quality Strategy targets.

Table 3-56—UHC CP QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Breast Cancer Screening[1]				
Breast Cancer Screening	62.06%	60.57%	-2.40%	★★★
Cervical Cancer Screening				
Cervical Cancer Screening	47.45%	48.18%	1.54%	★
Chlamydia Screening in Women				
16–20 Years	47.93%	45.78%	-4.49%	★
21–24 Years	59.56%	52.76%	-11.42%	★
Total	55.85%	50.09%	-10.31%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	73.11%	81.71%	11.76%	★★
Postpartum Care	52.32%	62.68%	19.80%	★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
2019 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 3-57. One rate in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, eight measure rates ranked at or above the 75th percentile, with two of these rates ranking above the 90th percentile. The remaining measure rates in this domain that could be compared to

[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*.

benchmarks ranked at or above the 50th percentile. There were seven measures[3-35] within this domain associated with an MQD Quality Strategy target for HEDIS 2019, with UHC CP QI meeting or exceeding the target for five measures, all related to *Comprehensive Diabetes Care* or *Medication Management for People With Asthma*.

Table 3-57—UHC CP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	92.93%	92.73%	-0.22%	★★★★
Diuretics	93.81%	93.18%	-0.67%	★★★★★
Total	93.20%	92.87%	-0.35%	★★★★★
Comprehensive Diabetes Care[1]				
HbA1c Testing	88.24%	88.81%	0.65%	★★★
*HbA1c Poor Control (>9.0%)**	33.86%	29.93%	-11.61%	★★★★
HbA1c Control (<8.0%)	54.93%	56.93%	3.64%	★★★★
Eye Exam (Retinal) Performed	67.41%	67.88%	0.70%	★★★★
Medical Attention for Nephropathy	92.85%	90.75%	-2.26%	★★★
Blood Pressure Control (<140/90 mm Hg)	68.04%	65.69%	-3.45%	★★★
Controlling High Blood Pressure[2]				
Controlling High Blood Pressure	—	68.86%	—	NC
Medication Management for People With Asthma[1]				
Medication Compliance 50%—Total	62.89%	69.01%	9.73%	★★★★
Medication Compliance 75%—Total	45.88%	46.01%	0.28%	★★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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). Due to technical specification changes in 2019, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Controlling High Blood Pressure* measure.

Behavioral Health Performance Measure Results

UHC CP QI's Behavioral Health performance measure results are shown in Table 3-58. Six of the rates in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Overall, for the measures that could be compared to benchmarks, nine measure rates ranked at or above the 50th percentile. Three of these measure rates ranked at or above the 75th percentile, including one measure rate that exceeded the 90th percentile. Conversely, one measure rate fell below the 25th percentile. Two measure rates demonstrated a relative decline of more than 10 percent in HEDIS 2019. Two measures[3-36] in this domain had an MQD Quality Strategy target for HEDIS 2019, and UHC CP QI did not meet either of the established targets, the 75th percentile.

Table 3-58—UHC CP QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment	52.37%	59.13%	12.91%	★★★★
Effective Continuation Phase Treatment	37.26%	44.89%	20.48%	★★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia[1]				
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	90.32%	—	★★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications[1]				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.68%	74.97%	-0.94%	★
Follow-Up After ED Visit for AOD Abuse or Dependence				
7 Day Follow-Up—13–17 Years	NA	NA	—	NC
7 Day Follow-Up—18+ Years	8.53%	10.96%	28.49%	★★★
7 Day Follow-Up—Total	8.64%	10.98%	27.08%	★★★
30 Day Follow-Up—13–17 Years	NA	NA	—	NC
30 Day Follow-Up—18+ Years	16.63%	18.98%	14.13%	★★★
30 Day Follow-Up—Total	16.63%	18.88%	13.53%	★★★
Follow-Up After ED Visit for Mental Illness[2]				
7-Day Follow-Up—Total	—	41.80%	—	NC
30-Day Follow-Up—Total	—	59.67%	—	NC
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—Total	50.62%	39.37%	-22.22%	★★★

[3-36] Within this domain, there were two MQD Quality Strategy targets: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total.*

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
30-Day Follow-Up—Total	61.73%	61.32%	-0.66%	★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	—	NC
Continuation and Maintenance Phase	NA	NA	—	NC
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness				
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	58.62%	42.00%	-28.35%	NC

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 3-59. Excluding *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*, *ED Visits for Ambulatory Care Sensitive Conditions*, 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 *Plan All-Cause Readmissions*, three measure rates demonstrated a relative improvement of more than 10 percent in HEDIS 2019. Additionally, all four *Plan All-Cause Readmissions* measure rates ranked at or above the 50th percentile; however, one of these measure rates demonstrated a relative increase of more than 10 percent for HEDIS 2019, indicating worse performance. Both *ED Visits for Ambulatory Care Sensitive Conditions* measure rates demonstrated a relative increase of more than 10 percent in HEDIS 2019, indicating worse performance. 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 3-59—UHC CP QI's HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	51.89	51.01	-1.70%	★★★
Outpatient Visits—Total[1]	460.05	442.12	-3.90%	NC
ED Visits for Ambulatory Care Sensitive Conditions*				
PCP Treatable ED Visits	10.22%	14.05%	37.44%	NC
Preventable/Avoidable ED Visits	47.98%	65.13%	35.75%	NC
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	20.37%	22.23%	9.13%	NC
20–44 Years Subtotal Percentage—Total	31.47%	31.05%	-1.33%	NC
45–64 Years Subtotal Percentage—Total	24.81%	24.08%	-2.94%	NC
65+ Years Subtotal Percentage—Total	23.35%	22.64%	-3.04%	NC
Inpatient Utilization—General Hospital/Acute Care—Total[1]				
Maternity—Average Length of Stay—Total	2.89	2.81	-2.77%	NC
Maternity—Days per 1,000 Member Months—Total	5.82	5.60	-3.78%	NC
Maternity—Discharges per 1,000 Member Months—Total	2.01	1.99	-1.00%	NC
Medicine—Average Length of Stay—Total	5.79	6.05	4.49%	NC
Medicine—Days per 1,000 Member Months—Total	38.25	35.67	-6.75%	NC
Medicine—Discharges per 1,000 Member Months—Total	6.61	5.90	-10.74%	NC
Surgery—Average Length of Stay—Total	10.23	8.84	-13.59%	NC
Surgery—Days per 1,000 Member Months—Total	32.45	23.63	-27.18%	NC
Surgery—Discharges per 1,000 Member Months—Total	3.17	2.67	-15.77%	NC
Total Inpatient—Average Length of Stay—Total	6.72	6.38	-5.06%	NC
Total Inpatient—Days per 1,000 Member Months—Total	74.48	62.92	-15.52%	NC
Total Inpatient—Discharges per 1,000 Member Months—Total	11.09	9.86	-11.09%	NC
Mental Health Utilization[2]				
Any Service—Total	—	11.68%	—	NC

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Inpatient—Total	—	0.60%	—	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.48%	—	NC
Outpatient—Total	—	11.22%	—	NC
*ED—Total**	—	0.95%	—	NC
Telehealth—Total	—	0.10%	—	NC
Plan All-Cause Readmissions[1]				
*Index Total Stays—Observed Readmissions—Ages 18–44**	12.25%	13.81%	12.73%	★★★
*Index Total Stays—Observed Readmissions—Ages 45–54**	17.44%	13.68%	-21.56%	★★★
*Index Total Stays—Observed Readmissions—Ages 55–64**	17.62%	15.34%	-12.94%	★★★
*Index Total Stays—Observed Readmissions—Total**	16.08%	14.46%	-10.07%	★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 63 measure rates comparable to benchmarks, 32 measure rates (50.8 percent) ranked at or above the 50th percentile, with 13 of these rates (20.6 percent) ranking above the 75th percentile, indicating positive performance in several areas, including access to care for elderly members, well-child visits for young children, medication management for members with asthma, care for members with diabetes, monitoring of members with cardiovascular disease and schizophrenia, and medication management for members on antidepressants. Additionally, UHC CP QI met five of the MQD Quality Strategy targets for HEDIS 2019: *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 50%—Total* and *Medication Compliance 75%—Total*.

Conversely, 31 of UHC CP QI's measure rates comparable to benchmarks (49.2 percent) fell below the 50th percentile, with 26 of these rates (41.3 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains. HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the 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—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
- 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)*, *Combination 2 (Meningococcal, Tdap, HPV)*, *Meningococcal*, and *Tdap*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Cervical Cancer Screening*
  - *Chlamydia Screening in Women—16–20 Years*, *21–24 Years*, and *Total*
- Behavioral Health
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Validation of Performance Improvement Projects

Findings

Getting Needed Care PIP

UHC CP QI's focus for this PIP was to increase the percentage of members who needed a BH appointment and responded "usually" or "always" to the survey question regarding the ease of ability to get an appointment as soon as they felt it was needed. Details of UHC CP QI's interventions for the PIP are presented in Table 3-60 and in the narrative below.

Table 3-60—Intervention Testing for *Getting Needed Care* PIP

Intervention	Key Drivers	Failure Modes	Conclusion
1. Member Services and Provider Types Training	• Inappropriate referral (i.e., wrong BH provider type, provider non-par, provider not accepting members with certain conditions) or lack of referral by originating provider and/or Member Services. • Member Services is not correctly intervening when the member calls and there is an incorrect/lack of referral by the member's PCP or other practitioner.	• Member attempts to go or goes to an incorrect type of provider. • Member may not be aware that the health plan provides direct-to-consumer BH support services.	The health plan chose to *adapt* the intervention.
2. Member Services and PCP Training on Telehealth	• Shortage of BH providers in Hawai'i County across all health plans. • Rural landscape poses transportation challenges due to the provider's and member's locations (time and distance of travel).	• Provider office may not know exactly what kind of services or supports the health plan provides. • Current telehealth services are being underutilized. • Members may not be able to get an appointment that fits their schedule.	The health plan chose to *adapt* the intervention.

The health plan tested two interventions and concluded:

- Despite the improper survey being used for the intervention, the health plan maintains that training Member Services advocates on BH provider types and their services can help to provide valuable benefit information to members and allow the health plan to serve as a useful resource.
- Adaptation of this intervention will incorporate lessons learned from the initial implementation and center on training member-facing staff to address knowledge gaps in BH services. UHC CP QI will explore how to best measure and reflect the impact of the training on member experience and outcomes to develop an adapted intervention effectiveness measure, with consideration of the administrative challenges of surveys. Additionally, UHC CP QI will examine adaptation to include more membership in the denominator to produce more meaningful data, rather than limiting the denominator only to those who actively call in to the health plan's call center.

HSAG validated UHC CP's *Getting Needed Care* PIP SMART Aim measure rates based on the results in Module 5. Table 3-61 below provides the level of confidence HSAG assigned to the PIP.

Table 3-61—SMART Aim Results for *Getting Needed Care* PIP

SMART Aim	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
By December 31, 2018, increase the rate of ease of access to a mental health specialist appointment as soon as the members felt they needed one, from 57.46% to 61.46%.	100%	Yes	No	*Reported PIP results were not credible*

The first intervention's results did not provide conclusive evidence that it impacted the SMART Aim measure, and the second intervention did not begin until after the health plan had stopped tracking on the SMART Aim measure. The health plan only provided three data points for the SMART Aim measure from May, June, and July 2018, and the denominator sizes were small—14, 8, and 8, respectively.

The PIP methodology was not executed as approved. The health plan should have provided SMART Aim measure results until the SMART Aim end date, December 31, 2018. Therefore, the PIP was assigned the confidence level, *Reported PIP results were not credible*.

Improving the Timeliness of Prenatal Care and Postpartum Care in Hawai'i County PIP

UHC CP QI's focus for this PIP was to increase the rate of members receiving timely prenatal care and postpartum care appointments. Details of UHC CP QI's interventions for the PIP are presented in Table 3-62 and in the narrative below.

Table 3-62—Intervention Testing for *Improving the Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* PIP

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
1. Provider Partnership: Early Identification—Provider List	• Member does not know what to do once she finds out she is pregnant. • Member does not have enough time (clinic hours, appointment does not address her needs, competing social determinants of health [SDOH]). • Member has other children, so she does not	• Woman has had other children and defers visits until she feels it is critical to attend. • Woman is not provided with information about the importance of seeking prenatal care in the first trimester.	The health plan chose to *adapt* the intervention.

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
	feel it is important to schedule an early appointment.		
2. Provider Partnership: Early Identification—Partnering with the Women, Infants, and Children (WIC) program.	• Member does not know what to do once she finds out she is pregnant. • Member does not have enough time (clinic hours, appointment does not address her needs, competing SDOH).	• Woman is not provided with information about the importance of seeking prenatal care in the first trimester. • Woman has other children and defers visits until she feels it is critical to attend. • Prenatal visits may not be captured by claims.	The health plan chose to *adapt* the intervention.
Postpartum Interventions	**Key Drivers**	**Failure Modes**	**Conclusion**
1. Provider Partnership: Early Identification—Provider List	• The members do not know that they need to go to the doctor again for a postpartum visit between 21–56 days after delivery. • This is not the member's first child, so she does not feel a need to follow up with her provider. • The member is focused on her newborn and does not have time to attend her own appointment or does not prioritize her appointment needs.	• Woman has had other children and does not feel it is important to schedule an appointment. • Member has a scheduling conflict; member is rescheduled, but not within HEDIS time frame. • Woman is not provided with information about the importance of seeking postpartum care 21–56 days post-delivery.	The health plan chose to *adapt* the intervention.
2. Member Rewards Program	• The member does not know that she needs to go to the doctor again for a postpartum visit between 21–56 days after delivery. • This is not the member's first child, so she does not feel a need to follow up with her provider. • The member is focused on her newborn and does not	• Woman has had other children and does not feel it is important to schedule an appointment. • Member has a scheduling conflict; member is rescheduled, but not within the HEDIS time frame. • Woman is not provided with information about	The health plan chose to *adapt* the intervention.

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
	have time to attend her own appointment or does not prioritize her appointment needs.	the importance of seeking postpartum care 21–56 days post-delivery.	

The health plan concluded:

- The deployed interventions did not demonstrate any improvements to achieve the SMART Aim. Lessons learned from the implemented interventions will be applied to future PIPs.

HSAG validated UHC CP QI's *Improving the Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* PIP SMART Aim measure rates based on the results in Module 5. Table 3-63 provides the level of confidence HSAG assigned to the PIP.

Table 3-63—Status of the *Improving the Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* PIP

SMART Aim	Measure	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
By December 31, 2018, UHC CP QI 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.	Prenatal	70.1%	No	Not Applicable	*Low Confidence*
	Postpartum	33.3%	No	Not Applicable	

The health plan did not meet the SMART Aim goal for either prenatal or postpartum care, and all monthly results were below the reported baselines and goals. HSAG assigned the PIP a level of *Low Confidence*.

Strengths and Weaknesses

The validation findings suggest that for the *Getting Needed Care* PIP, UHC CP QI did not execute the PIP methodology as approved. Therefore, HSAG assigned a confidence level of *Reported PIP results were not credible* to the PIP.

For the *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i* County PIP, UHC CP QI did not meet the SMART Aim goal for either prenatal or postpartum care, and all the monthly results were below the reported baselines and goals. HSAG assigned the PIP a level of *Low Confidence*.

UHC CP QI identified the following key learnings from its two PIPs:

Getting Needed Care:

- The health plan needs to consider intervention measures that can better reflect the impact of a process change on the overall study aim.
- The true impact of staff and PCP network training on the members' experience is especially challenging within a rapid-cycle PIP.
- The health plan needs to ensure interventions include denominator sizes large enough for valid data analysis, especially when using surveys as a measurement tool.

Improving the Timeliness of Prenatal Care and Postpartum Care in Hawai'i County:

- The health plan needs to either narrow the study question scope or be able to collect data from the interventions that mirror the overall PIP study population.
- The health plan needs to improve communication among involved team members to avoid gaps in understanding and incorrect project implementation.
- Three-month time frames were likely too short to produce meaningful data, especially since the interventions produced such small denominators.
- Interventions such as home visits, daycare, transportation support services, and larger provider and member incentives that the health plan feels may better address key drivers are difficult to implement in rapid-cycle PIPs and are better suited for non-rapid cycle projects due to the time and resources needed to plan, deploy, and evaluate them.

Recommendations for Improvement

- UHC CP QI should ensure that the approved methodologies for the PIP are followed and report PIP results accurately and completely, according to the approved methodologies.
- UHC CP QI should ensure that intervention evaluation is completed to measure the impact of the intervention.
- UHC CP QI should ensure that interventions are started in a timely manner and reach enough members to impact the SMART Aim.
- UHC CP QI should ensure the health plan's internal PIP team consistently participates in the project to ensure understanding and a complete transition when there is staff turnover.
- UHC CP QI should apply the lessons learned and knowledge gained to future PIPs and quality improvement activities.

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

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

- Trend Analysis
- NCQA Comparisons
- Key Drivers of Member Experience Analysis

Findings

Table 3-64 presents the 2019 percentage of top-box responses for UHC CP QI compared to the 2018 NCQA child Medicaid national averages and the corresponding 2017 scores.[3-37,3-38,3-39] Additionally, the overall member experience ratings (i.e., star ratings) resulting from UHC CP QI's top-box scores compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-40]

Table 3-64—Child Medicaid CAHPS Results *for* UHC CP QI

Measure	2017 Scores	2019 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	66.3%	65.9%	★
Rating of All Health Care	60.2%	66.0%	★
Rating of Personal Doctor	70.5%	65.3%	★
Rating of Specialist Seen Most Often	75.9%	66.7%+	★
Composite Measures			
Getting Needed Care	81.5%	80.2%	★
Getting Care Quickly	81.6%	83.0%	★
How Well Doctors Communicate	93.5%	92.6%	★★
Customer Service	85.2%	84.1%+	★
Shared Decision Making	85.8%+	80.9%+	★★★

[3-37] 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.
[3-38] The adult population was last surveyed in 2018; therefore, the 2019 child CAHPS scores are compared to the corresponding 2017 scores.
[3-39] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2018.
[3-40] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

Measure	2017 Scores	2019 Scores	Star Ratings
Individual Item Measures			
Coordination of Care	85.0%	83.3%+	★★★
Health Promotion and Education	75.0%	76.6%	★★★★

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child Medicaid national averages.
▲ Indicates the 2019 score is statistically significantly higher than the 2017 score.
▼ Indicates the 2019 score is statistically significantly lower than the 2017 score.
+ 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

Strengths

For UHC CP QI's child Medicaid population, the following three measures met or exceeded the 2018 NCQA child Medicaid national averages:

- *Shared Decision Making*
- *Coordination of Care*
- *Health Promotion and Education*

None of the three MQD beneficiary satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—met or exceeded the 75th percentile for UHC CP QI.

Areas for Improvement

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. 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 experience with each of the three measures; therefore, UHC CP QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-65 provides a summary of the key drivers identified for UHC CP QI.

Table 3-65—UHC CP QI Key Drivers of Member Experience Analysis

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.		✓	

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that a doctor or other health provider did not always talk to them about specific things they could do to prevent illness in their child.	✓	✓	✓
Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.			✓
Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.	✓	✓	✓
Respondents reported that their child's personal doctor did not always spend enough time with them.			✓
Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.	✓	✓	
Respondents reported that they did not always receive the information or help they needed from customer service at their child's health plan.	✓	✓	
Respondents reported that forms from their child's health plan were often not easy to fill out.	✓		

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

- Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.
- Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.

The following observations from the key drivers of member experience analysis indicate areas for improvement in quality of care for UHC CP QI:

- Respondents reported that a doctor or other health provider did not always talk to them about specific things they could do to prevent illness in their child.
- Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.
- Respondents reported that their child's personal doctor did not always spend enough time with them.

- Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.
- Respondents reported that they did not always receive the information or help they needed from customer service at their child's health plan.
- Respondents reported that forms from their child's health plan were often not easy to fill out.

Overall Assessment of Quality, Access, and Timeliness of Care

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

Conclusions

In general, UHC CP QI's performance results illustrated mixed performance across the four EQR activities. While the compliance monitoring review activity revealed that UHC CP QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, UHC CP QI had yet to fully implement the revised managed care regulations released in 2016. In addition, performance on outcome and process measures showed room for improvement.

UHC CP QI's performance during the 2019 compliance review was above average, meeting or exceeding the statewide compliance score for all six standards. UHC CP QI performed strongest in the *Access and Availability* and *Coordination and Continuity of Care* standards with 100 percent compliance and lowest in the *Member Information* standard with 73 percent compliance. UHC CP QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor UHC CP QI's CAP activities until the health plan is found to be in full compliance.

Overall, just under half (49.2 percent) of UHC CP QI's measure rates fell below the 50th percentile, with 41.3 percent of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS 2018, UHC CP QI's performance demonstrated the need to improve process and outcome measures across most 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 two-thirds of the measure rates fell below the 25th percentile. Overall, only five of the MQD's 14 Quality Strategy targets were met in HEDIS 2019.

Similarly, UHC CP QI's CAHPS results illustrate opportunities for improvement in members' experiences with care. While none of the measures scored statistically significantly lower in 2019 than in 2017, the following eight measures were below the 50th percentiles and the 2018 NCQA child 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*, and *Customer Service*.

Finally, the results of UHC CP QI's PIPs indicate a need for ongoing quality improvement training of staff. HSAG assessed UHC CP QI's *Getting Needed Care* PIP as *Results Not Credible* and *Improving the Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* as *Low Confidence.* These results suggest that UHC CP QI continues to have opportunities for improvement in executing the rapid-cycle PIP process. Additionally, in 2019, UHC CP QI submitted Module 1 and Module 2 for two new PIP topics specified by the MQD (*Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness)* and, at the time of this report, was in the process of resubmitting Module 1 and Module 2 to achieve all validation criteria before progressing to Module 3.

UHC CP QI's performance on the *Coordination and Continuity of Care* compliance standard was strong and may also be supported by the MCO's CAHPS performance in care coordination and health promotion, for which both measures rated at or above Medicaid national averages. These results highlight strengths in areas related to healthcare quality. Conversely, while the compliance findings suggest UHC CP QI's strength related to the *Access and Availability* standard, the MCO's HEDIS measure performance in the Access to Care domain, coupled with the less-than-average CAHPS performance in access to care-related measures suggest opportunities for improvement in the access to care domain overall for UHC CP QI. This is further supported by UHC CP QI's performance on the *Getting Needed Care* and *Improving Timeliness of Prenatal and Postpartum Care* PIPs, where results from one PIP were assessed as not credible and the other assessed as *Low Confidence*. Poor performance related to prenatal and postpartum care may also indicate barriers in accessing needed care before and after delivery. Since CAHPS survey measures assess members' perceptions, poor performance on the *Getting Needed Care* and *Getting Care Quickly* measures indicates that members perceive barriers when accessing care. These perceptions may be confirmed when access-related measures, such as *Children and Adolescents' Access to Primary Care Practitioners* and *Adults' Access to Preventive/Ambulatory Health Services*, fail to meet the national average. UHC CP QI would benefit from applying the QI tools and techniques learned from the rapid-cycle PIP process to identify and overcome the root cause for its subpar performance in the access to care domain.

'Ohana Community Care Services ('Ohana CCS) Results

Compliance Monitoring Review

The 2019 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-66 presents the standards and compliance scores for 'Ohana CCS.

Table 3-66—Standards and Compliance Scores—'Ohana CCS

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	27	5	84%
II	Access and Availability	13	11	2	85%
III	Coordination and Continuity of Care	9	6	3	67%
IV	Member Rights and Protections	9	8	1	89%
V	Member Information	21	16	5	76%
VI	Member Grievance System	27	19	8	70%
	Totals	**111**	**87**	**24**	**78%**

Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.

Strengths

'Ohana CCS was found to be 89 percent compliant with the Member Rights and Protections standard, with only one element scoring a *Not Met.* 'Ohana CCS had policies, procedures, and written member and provider information regarding member rights. The health plan ensured that member rights were protected by educating staff via trainings and monitoring call center staff members to evaluate adherence to member rights. 'Ohana CCS also reviewed member grievances related to violations of rights, which provided an opportunity to identify and retrain staff and providers on member rights. In addition, 'Ohana CCS disseminated information to members, providers, and employees regarding nondiscrimination policies and the applicable federal and State laws.

Areas for Improvement

'Ohana CCS was found to be 85 percent compliant with the *Access and Availability* standard, with two elements scoring a *Not Met*. 'Ohana CCS had systems, policies, processes, and organizational structure

in place to regularly evaluate and monitor access to and availability of its services and network providers for enrolled members. 'Ohana CCS used GeoAccess reporting/analysis and a network adequacy tool to evaluate its network and generate reports showing any gaps in the network as measured by the distance from the members' residence to the nearest BH provider or specialist. While 'Ohana CCS policies and procedures ensured the provider network consisted of, at a minimum, the providers necessary to render all covered services, the policy did not clearly define how 'Ohana CCS used the criteria to establish and maintain its provider network. In addition, 'Ohana CCS policies did not specify that case management services were available 24 hours a day, seven days a week, when medically necessary, at the member's location.

'Ohana CCS was found to be compliant with 84 percent of the Coverage and Authorization of Services standard, with five elements scoring a *Not Met.* 'Ohana CCS provided evidence through its written documentation and interview responses that it had the mechanisms in place to communicate to its members and providers the policies and procedures for coverage and authorization decisions. While 'Ohana CCS documentation was sometimes inconsistent, interview responses during the on-site compliance review described how the behavioral health organization (BHO) staff managed benefit requests, issued coverage/authorization determinations, and communicated those decisions to members and providers. The corrective actions required by 'Ohana CCS were related to updating policies and procedures to align with State and federal requirements, updating member notification letter templates to include all required language, and revising and implementing processes to ensure member notification letters were written at or below a sixth-grade reading level.

'Ohana CCS was found to be 76 percent compliant with the Member Information standard, with five elements scoring a *Not Met.* In general, 'Ohana CCS had member information and call center staff members available to help members understand the requirements and benefits of the plan. The corrective actions required by 'Ohana CCS were related to member handbook updates to ensure correct information was provided to members, website updates, provider directory updates, and policy and procedure updates to align with current processes for disseminating the provider directory.

'Ohana CCS was found to be compliant with 70 percent of the Member Grievance System standard, with eight elements scoring a *Not Met.* While 'Ohana CCS had comprehensive policies and procedures for the processing of grievances and appeals, some of the processes and time frames used by the health plan were not in alignment with the current federal regulations and State contracts. The corrective actions required by 'Ohana CCS were related to updating policies, procedures, member notification letter templates, and provider information to be in compliance with federal and State regulations.

'Ohana CCS was found to be compliant with 67 percent of the Coordination and Continuity of Care standard, with three elements scoring a *Not Met*. 'Ohana CCS has policies and procedures to coordinate timely, cost-effective BH services for the individual health needs of Hawaii's Medicaid members who had been deemed seriously and persistently mentally ill. The BHO's documentation and interview responses outlined the procedures used to proactively assess and plan, implement, coordinate, monitor, and evaluate the options and BH services required to meet the member's healthcare needs using all available resources. The required corrective actions included updating and finalizing the care

coordination policies and implementing mechanisms to monitor care coordination activities to ensure compliance with federal and State requirements.

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 six 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 2019 measure reporting.

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

- HSAG recommended that 'Ohana CCS ensure 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 3-67. Both rates in this domain demonstrated a relative decline of more than 10 percent in HEDIS 2019. Additionally, both measure rates fell below the 50th percentile, including one measure rate that fell below the 25th percentile.

Table 3-67—'Ohana CCS' HEDIS Results for QI Measures Under Access to Care

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	42.60%	33.33%	-21.76%	★
Engagement of AOD Treatment—Total	15.62%	9.88%	-36.75%	★★

2019 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

'Ohana CCS' Behavioral Health performance measure results are shown in Table 3-68. Two measures in this domain had an MQD Quality Strategy target for HEDIS 2019, and 'Ohana CCS met or exceeded both of the established targets, the 75th percentile.

Two measure rates within this domain reported a relative improvement of more than 10 percent in HEDIS 2019. Additionally, three measure rates ranked at or above the 75th percentile, with two of these rates exceeding the 90th percentile. Conversely, two measure rates fell below the 50th percentile, with one of these measure rates falling below the 25th percentile. Additionally, two measure rates in this domain had a relative decline of more than 10 percent in HEDIS 2019. Two measures[3-41] in this domain had an MQD Quality Strategy target for HEDIS 2019, and 'Ohana CCS met or exceeded both of the established targets, the 75th percentile.

Table 3-68—'Ohana CCS' HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Adherence to Antipsychotic Medications for Individuals with Schizophrenia[1]				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	65.92%	70.24%	6.55%	★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	44.01%	41.63%	-5.41%	★
Effective Continuation Phase Treatment	32.39%	33.47%	3.33%	★★
Behavioral Health Assessment				
BHA Completion Within 30 Days of Enrollment (Within Standard)	45.40%	46.20%	1.77%	NC

[3-41] Within this domain, there were two MQD Quality Strategy targets: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total.*

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
BHA Completion Within 31–60 Days of Enrollment (Not Within Standard)	22.85%	12.25%	-46.40%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence				
7 Day Follow-Up—13–17 Years	NA	NA	—	NC
7 Day Follow-Up—18+ Years	13.98%	13.10%	-6.29%	★★★
7 Day Follow-Up—Total	13.98%	13.10%	-6.29%	★★★
30 Day Follow-Up—13–17 Years	NA	NA	—	NC
30 Day Follow-Up—18+ Years	20.81%	23.96%	15.14%	★★★
30 Day Follow-Up—Total	20.81%	23.96%	15.14%	★★★
Follow-Up After ED Visit for Mental Illness[2]				
7-Day Follow-Up—Total	—	54.04%	—	NC
30-Day Follow-Up—Total	—	76.30%	—	NC
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—Total	74.19%	66.44%	-10.45%	★★★★★
30-Day Follow-Up—Total	90.32%	82.53%	-8.62%	★★★★★

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 2019, NCQA recommends exercising caution when trending between HEDIS 2019 and prior years.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 3-69. Excluding *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 2019.

Table 3-69—Ohana CCS' HEDIS Results for QI Measures Under Utilization and Health Plan Descriptive Information

Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	Relative Difference	2019 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	128.37	130.46	1.63%	★
Outpatient Visits—Total[1]	728.99	634.10	-13.02%	NC
Enrollment by Product Line—Total				
0–19 Years Subtotal Percentage—Total	0.28%	0.24%	-14.29%	NC
20–44 Years Subtotal Percentage—Total	30.36%	29.88%	-1.58%	NC
45–64 Years Subtotal Percentage—Total	57.94%	57.40%	-0.93%	NC
65+ Years Subtotal Percentage—Total	11.42%	12.48%	9.28%	NC
Mental Health Utilization[1]				
Any Service—Total	—	99.99%	—	NC
Inpatient—Total	—	8.41%	—	NC
Intensive Outpatient or Partial Hospitalization—Total	—	15.81%	—	NC
Outpatient—Total	—	98.74%	—	NC
*ED—Total**	—	14.73%	—	NC
Telehealth—Total	—	6.41%	—	NC

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' 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.
2019 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 the 12 'Ohana CCS measure rates with comparable benchmarks, seven of these measures rates (58.3 percent) ranked above the 50th percentile, three of which (25.0 percent) ranked at or above the 75th percentile, indicating positive performance related to antipsychotic medication adherence and follow-up after a discharge for mental illness. Three measure rates (25.0 percent) fell below the 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 25th percentile for the QI population:

- Access to Care

  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
- Behavioral Health
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
- Utilization and Health Plan Descriptive Information
  - *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*

Validation of Performance Improvement Projects

Findings

Follow-Up After Hospitalization (FUH) for Mental Illness PIP

'Ohana CCS' focus for this PIP was to increase the rate of follow-up within seven days for members with a discharge from hospitalization for mental illness. Details of 'Ohana CCS' intervention for the PIP are presented in Table 3-70 and in the narrative below.

Table 3-70—Intervention Testing for *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP

Intervention	Key Driver	Failure Mode	Conclusion
Community Based Case Management (CBCM) agency staff to visit the member while inpatient or make arrangements for community outreach.	Member cannot be reached for reminder regarding follow-up appointment within seven days.	Member cannot be reached for reminder regarding follow-up appointment within seven days.	The health plan chose to *abandon* the intervention.

The health plan tested the intervention from March 2018 through December 2018.

The health plan concluded:

- The intervention was ineffective.
- Data for the intervention may not have been captured accurately. Case managers are often busy, and the tracker was not within their normal workflow.

HSAG validated 'Ohana CCS' *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP SMART Aim measure rates based on the results in Module 5. Table 3-71 below provides the level of confidence HSAG assigned to the PIP.

Table 3-71—SMART Aim Results for *Follow-Up After Hospitalization (FUH) for Mental Illness* PIP

SMART Aim	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
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%.	86.0%	Yes	No	*Low Confidence*

The health plan achieved the SMART Aim measure goal; however, based on the intervention effectiveness measure data and SMART Aim measure run chart data, the tested intervention cannot be linked to improvement in the SMART Aim measure rate. HSAG assigned a final rating of *Low Confidence* to this PIP.

Behavioral Health Assessment PIP

'Ohana CCS' focus for this PIP was to improve BHA compliance rates of newly enrolled members. Details of 'Ohana CCS' intervention for the PIP are presented in Table 3-72 and in the narrative below.

Table 3-72—Intervention Testing for *Behavioral Health Assessment* PIP

Intervention	Key Driver	Failure Mode	Conclusion
Follow-Up email notification from health plan to agency.	CBCM agency is not aware of the new member.	CBCM agency is not aware of the new member.	The health plan chose to *adopt* the intervention.

The health plan tested the intervention from March 2018 through December 2018.

The health plan concluded:

- The intervention succeeded in continuously keeping the rate above 16 percent for most measurement periods.

HSAG validated 'Ohana CCS' *Behavioral Health Assessment* PIP SMART Aim measure rates based on the results in Module 5. Table 3-73 provides the level of confidence HSAG assigned to the PIP.

Table 3-73—Status of the *Behavioral Health Assessment* PIP

SMART Aim	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, improve BHA compliance rates of newly enrolled CCS members assigned in 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%.	74.0%	Yes	No	*Low Confidence*

Even though the SMART Aim goal of 50 percent was exceeded in May 2018, the rate remained below the goal for the remaining months. HSAG assigned a final rating of *Low Confidence* to the PIP.

Strengths and Weaknesses

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

‘Ohana CCS identified the following key learnings from its two PIPs:

Follow-Up After Hospitalization (FUH) for Mental Illness PIP:

- Data for the intervention were captured manually and may not have captured all interventions that were completed.
- Toward the end of the measurement period, the intervention may not have been captured as frequently as it was occurring, compared to the beginning of the measurement period.
- The project may have lost momentum as the new contract requirements were in place effective October 2018.

Behavioral Health Assessment:

- The health plan began capturing the reasons for incomplete BHAs. Although most of these reasons were not captured, the health plan learned that identifying the reasons for incomplete BHAs is the next step to improve performance rates.

Recommendations for Improvement

- 'Ohana CCS should ensure that the results and interpretation are provided accurately and completely in the PIP documentation.
- 'Ohana CCS should ensure that collected monthly intervention data are complete and can provide a clear linkage between improvement in the SMART Aim measure results and change(s) tested for the PIP.
- 'Ohana CCS should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.

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 mixed 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 of, access to, and timeliness of care and service delivery, 'Ohana CCS had yet to fully implement the revised managed care regulations released in 2016. In addition, 'Ohana CCS' performance on outcome and process measures was mixed and highlighted some room for improvement.

'Ohana CCS' performance during the 2019 compliance review was average, meeting or exceeding the statewide compliance score for four of the six standards. It did not score 100 percent in any of the standards, resulting in 24 elements requiring corrective action. 'Ohana CCS performed strongest in the *Member Rights and Protections* standard and the lowest in the *Coordination and Continuity of Care* standard. 'Ohana CCS was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

Overall, seven (58.3 percent) of 'Ohana CCS' measure rates ranked above the 50th percentile, while three measure rates fell below the 25th percentile. Two measure rates in the Behavioral Health domain (i.e., both *Follow-Up After Hospitalization for Mental Illness* rates) exceeded the MQD Quality Strategy target, the 90th percentile.

Finally, the results of 'Ohana CCS' PIPs indicate a need for ongoing quality improvement training of staff. HSAG assessed 'Ohana CCS' *Follow-Up After Hospitalization for Mental Illness* and *Behavioral Health Assessment* PIPs both as *Low Confidence.* While the validation findings determined that 'Ohana CCS met the SMART Aim goals for both PIPs, the quality improvement processes and implemented interventions could not be linked to the demonstrated improvement. These results suggest that 'Ohana

CCS continues to have opportunities for improvement in executing the rapid-cycle PIP process. Additionally, in 2019, ‘Ohana CCS submitted Module 1 and Module 2 for two new PIP topics specified by the MQD (*Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness*) and, at the time of this report, was in the process of resubmitting Module 1 and Module 2 to achieve all validation criteria before progressing to Module 3.

‘Ohana CCS’ compliance review findings, HEDIS measure performance, and PIP results suggest opportunities for improvement related to access to care. Further, ‘Ohana CCS’ performance relative to care coordination suggests opportunities for improvement related to quality of care. While the BHO’s HEDIS rates for the *Follow-Up After Hospitalization for Mental Illness* measure were at or above the 90th percentile, ‘Ohana CCS’ rate for the *ED Visits—Total* measure was below the 25th percentile, indicating high utilization of the emergency room by its members. High emergency department utilization may indicate barriers in accessing certain behavioral health services or providers, such as crisis response or substance use disorder services. ‘Ohana CCS would benefit from evaluating current care coordination processes and provider network adequacy and implementing operational changes to support the care needs of the BHO’s challenging member population.

4. Comparative Analysis of Health Plan Performance

Introduction

This section compares the EQR activity results across the Hawaii health plans and provides comparisons to statewide scores and/or national benchmarks, as appropriate.

Compliance Monitoring Review

Table 4-1 summarizes the results from the 2019 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plans scores with red shading indicate performance below the statewide score.

Table 4-1—Compliance Standards and Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
Coverage and Authorization of Services	78%	88%	75%	72%	88%	84%	**81%**
Access and Availability	100%	100%	88%	88%	100%	85%	**94%**
Coordination and Continuity of Care	90%	90%	80%	100%	100%	67%	**88%**
Member Rights and Protections	89%	56%	56%	89%	89%	89%	**78%**
Member Information	82%	64%	59%	77%	73%	76%	**72%**
Member Grievance System	56%	74%	70%	67%	78%	70%	**69%**
Totals	**78%**	**79%**	**72%**	**78%**	**85%**	**78%**	**78%**

***Total Compliance Score*:** The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.

Statewide areas with the strongest performance were *Access and Availability* (94 percent) and *Coordination and Continuity of Care* (88 percent). The health plans' performance among the remaining four standards was variable across all plans, with the *Member Grievance System* and *Member Information* standards identified as having the greatest opportunities for improvement.

Total health plan scores ranged from 72 percent to 85 percent. The total statewide compliance score of 78 percent indicated a low degree of compliance with managed care requirements and the health plans' limited implementation of the revised managed care regulations released in 2016.

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

UHC CP QI had the highest overall compliance score this year and, therefore, the fewest number of standard areas requiring CAPs. KFHP QI was the lowest-scoring plan, falling below the statewide score in five of the six standards. For all the programs, the *Member Information* and *Member Grievance System* standards represented the greatest opportunity for improvement.

Validation of Performance Measures—HEDIS Compliance Audits

NCQA HEDIS Compliance Audits

Table 4-2 compares each QI health plan's compliance with each information system (IS) standard reviewed during the 2019 NCQA HEDIS Compliance Audit. With the exception of IS standard 5.0 for UHC CP QI, all QI health plans exhibited fully compliant information systems in support of performance measure calculation and reporting.

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*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
HMSA QI	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully 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*	*Partially 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' 2019 measure rates and their performance relative to the NCQA national Medicaid HEDIS 2018 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 HEDIS 2019 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	60.80% ★	71.21% ★	80.68% ★★★	59.44% ★	57.74% ★
45–64 Years	72.99% ★	81.95% ★	90.07% ★★★★	79.25% ★	79.23% ★
65 Years and Older	80.58% ★	84.90% ★★	96.68% ★★★★★	88.81% ★★★	94.79% ★★★★★
Total	66.52% ★	75.53% ★	85.10% ★★★★	72.97% ★	76.62% ★★
Children and Adolescents' Access to Primary Care Practitioners					
12–24 Months	95.31% ★★	97.21% ★★★★	98.67% ★★★★★	92.74% ★	93.21% ★
25 Months–6 Years	84.22% ★	88.67% ★★★	92.92% ★★★★★	76.10% ★	77.36% ★
7–11 Years	86.74% ★	90.70% ★★★	88.38% ★★	81.40% ★	81.01% ★
12–19 Years	85.32% ★	89.97% ★★★	87.90% ★★	79.59% ★	80.00% ★
Initiation and Engagement of AOD Abuse or Dependence Treatment					
Initiation of AOD Treatment—Total	36.71% ★	35.60% ★	33.19% ★	35.12% ★	33.37% ★

[4-1] HEDIS 2019 performance measure rates were compared to HEDIS Quality Compass national Medicaid percentiles for HEDIS 2018.

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Engagement of AOD Treatment—Total	9.93% ★★	14.52% ★★★	8.35% ★	10.64% ★★	9.18% ★★

Within the Access to Care performance measure domain, KFHP QI performed best among the health plans, with five measure rates ranking at or above the 75th percentile, three of which ranked at or above the 90th percentile. AlohaCare QI and ‘Ohana QI demonstrated the worst performance among the health plans, with eight measure rates for each health plan falling below the 25th percentile. Health plans demonstrated the worst performance for the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure, with only one plan meeting the 50th percentile for one of the two measure indicators.

There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2019.

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 HEDIS 2019 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	50.61% ★★	52.80% ★★	42.34% ★	49.15% ★★	44.28% ★
Childhood Immunization Status					
Combination 3	59.61% ★	71.53% ★★★	81.17% ★★★★★	50.16% ★	63.07% ★
DTaP	66.18% ★	77.86% ★★★	83.50% ★★★★	58.26% ★	68.09% ★
Hepatitis B	78.59% ★	86.13% ★	92.26% ★★★	73.83% ★	81.16% ★
HiB	79.56% ★	88.32% ★★	90.07% ★★★	78.19% ★	80.40% ★
IPV	81.75% ★	87.10% ★★	91.68% ★★★	74.14% ★	80.40% ★
MMR	78.59% ★	89.05% ★★	90.80% ★★★	77.57% ★	81.91% ★
Pneumococcal Conjugate	66.67% ★	76.64% ★★	82.34% ★★★★	58.26% ★	68.09% ★
VZV	77.62% ★	86.62% ★	90.51% ★★★	74.77% ★	80.90% ★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	56.45% ★	66.42% ★	83.98% ★★★	48.28% ★	54.60% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Combination 2 (Meningococcal, Tdap, HPV)	25.55% ★	28.71% ★★	47.08% ★★★★★	18.62% ★	26.07% ★
HPV	28.47% ★★	31.63% ★★	47.63% ★★★★	22.07% ★	29.14% ★★
Meningococcal	59.12% ★	69.59% ★	85.24% ★★★	53.10% ★	59.20% ★
Tdap	62.53% ★	70.80% ★	86.35% ★★	52.76% ★	59.20% ★
Well-Child Visits in the First 15 Months of Life					
*No Well-Child Visits**	0.73% ★★★★	1.72% ★★	0.46% ★★★★★	3.88% ★	1.44% ★★★
Six or More Well-Child Visits	73.48% ★★★★	71.26% ★★★	74.92% ★★★★	67.31% ★★★	72.70% ★★★★
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	66.18% ★	71.18% ★★	86.53% ★★★★★	62.23% ★	61.99% ★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—Total	85.89% ★★★★	85.11% ★★★★	95.83% ★★★★★	79.56% ★★★	79.64% ★★★
Counseling for Nutrition—Total	71.05% ★★★	75.93% ★★★	98.33% ★★★★★	75.67% ★★★	73.45% ★★★
Counseling for Physical Activity—Total	65.94% ★★★	71.22% ★★★	97.50% ★★★★★	70.56% ★★★	68.56% ★★★

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.*

Within the Children's Preventive Health performance measure domain, KFHP QI performed best among the health plans, with 11 measure rates ranking at or above the 75th percentile, seven of which exceeded the 90th percentile. 'Ohana QI demonstrated the worst performance among the health plans, with only four 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 Documentation—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*) ranking above the national Medicaid 50th percentile, and the remaining 15 measure rates ranking below the 25th percentile. Health plans demonstrated the worst performance for *Adolescent Well-Care Visits* and *Immunizations for Adolescents—Tdap*, with all health plans ranking below the national Medicaid 50th percentile for both indicators. Health plan performance was best for the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure and all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measures, as all health plans performed above the national Medicaid 50th percentile for 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 HEDIS 2019. KFHP QI was the only health plan to meet or exceed 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 HEDIS 2019 Women's Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Breast Cancer Screening					
Breast Cancer Screening	50.39% ★	60.23% ★★★	79.03% ★★★★★	51.35% ★	60.57% ★★★
Cervical Cancer Screening					
Cervical Cancer Screening	54.74% ★★	63.30% ★★★	78.51% ★★★★★	45.26% ★	48.18% ★
Chlamydia Screening in Women					
16-20 Years	37.44% ★	48.52% ★★	77.28% ★★★★★	27.88% ★	45.78% ★
21-24 Years	45.24% ★	56.43% ★	82.06% ★★★★★	44.63% ★	52.76% ★
Total	41.04% ★	52.29% ★★	79.41% ★★★★★	37.84% ★	50.09% ★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	78.83% ★★	77.62% ★★	92.59% ★★★★★	75.62% ★	81.71% ★★
Postpartum Care	54.50% ★	55.72% ★	80.37% ★★★★★	48.77% ★	62.68% ★★

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, with all seven measure rates exceeding the 90th percentile. 'Ohana QI demonstrated the worst performance among the health plans, with all measure rates falling below the 25th percentile. Additionally, AlohaCare QI also showed low performance, with all measure rates falling below the 50th percentile. Both *Prenatal and Postpartum Care* measure rates and all three *Chlamydia Screening in Women* measure rates ranked below the 50th percentile across all health plans except KFHP QI.

There were three measures[4-2] within the Women's Health domain associated with an MQD Quality Strategy target in HEDIS 2019. KFHP QI was the only health plan to meet or exceed the target for all three measures: *Breast Cancer Screening*, *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*.

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 HEDIS 2019 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	86.21% ★★	85.60% ★	92.25% ★★★★	92.35% ★★★★	92.73% ★★★★
Diuretics	87.69% ★★	85.05% ★	92.37% ★★★★	93.01% ★★★★★	93.18% ★★★★★
Total	86.69% ★★	85.42% ★	92.28% ★★★★	92.55% ★★★★	92.87% ★★★★★
Comprehensive Diabetes Care					
HbA1c Testing	86.62% ★★	87.35% ★★	94.59% ★★★★★	88.08% ★★★	88.81% ★★★
*HbA1c Poor Control (>9.0%)**	42.34% ★★	42.82% ★★	33.11% ★★★	39.66% ★★	29.93% ★★★★
HbA1c Control (<8.0%)	47.20% ★★	43.80% ★	56.16% ★★★★	51.58% ★★★	56.93% ★★★★
Eye Exam (Retinal) Performed	60.83% ★★★	67.15% ★★★★	66.91% ★★★★	65.45% ★★★★	67.88% ★★★★
Medical Attention for Nephropathy	86.62% ★	89.54% ★★	95.20% ★★★★★	91.48% ★★★	90.75% ★★★
Blood Pressure Control (<140/90 mm Hg)	60.58% ★★	48.66% ★	79.08% ★★★★★	63.02% ★★★	65.69% ★★★
Controlling High Blood Pressure[1]					
Controlling High Blood Pressure	53.77% —	53.28% —	77.62% —	62.53% —	68.86% —
Medication Management for People With Asthma					
Medication Compliance 50%—Total	60.70% ★★★	61.97% ★★★	58.85% ★★	63.21% ★★★	69.01% ★★★★
Medication Compliance 75%—Total	36.53% ★★★	41.04% ★★★	31.86% ★★	42.45% ★★★	46.01% ★★★★

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 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.

Within the Care for Chronic Conditions performance measure domain, UHC CP QI performed best among the health plans, with all measure rates that could be compared to benchmarks ranking at or above the 50th percentile. Additionally, eight of UHC CP QI's measure rates ranked at or above the 75th percentile, including two that exceeded the 90th percentile. KFHP QI's performance was similar, with

eight measure rates ranking at or above the 75th percentile, three of which were at or above the 90th percentile. HMSA QI and AlohaCare QI demonstrated the worst performance among the health plans, with both health plans having eight measure rates fall below the 50th percentile.

Seven measures[4-3] within the Care of Chronic Conditions domain were associated with an MQD Quality Strategy target in HEDIS 2019. KFHP QI and UHC CP QI each met or exceeded five targets, 'Ohana QI met or exceeded two targets, and HMSA QI met or exceeded one target. AlohaCare QI was the only health plan that did not meet any targets within the Care of Chronic Conditions domain.

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 HEDIS 2019 Behavioral Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Antidepressant Medication Management					
Effective Acute Phase Treatment	51.00% ★★	50.40% ★★	64.53% ★★★★	48.22% ★	59.13% ★★★★
Effective Continuation Phase Treatment	33.55% ★★	33.91% ★★	43.24% ★★★★	36.76% ★★★	44.89% ★★★★
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NA	90.32% ★★★★★
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	73.03% ★	69.59% ★	85.60% ★★★★	73.24% ★	74.97% ★
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence					
7 Day Follow-Up—13-17 Years	11.43% ★★★★	9.09% ★★★	NA	NA	NA
7 Day Follow-Up—18+ Years	12.10% ★★★	15.40% ★★★	12.20% ★★★	9.06% ★★	10.96% ★★★
7 Day Follow-Up—Total	12.05% ★★★	14.91% ★★★	14.29% ★★★	8.90% ★★	10.98% ★★★
30 Day Follow-Up—13-17 Years	20.00% ★★★★	9.09% ★★★	NA	NA	NA

[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). Due to technical specification changes for HEDIS 2019, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Controlling High Blood Pressure* measure.

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
30 Day Follow-Up—18+ Years	19.76% ★★★	22.85% ★★★	17.07% ★★★	18.73% ★★★	18.98% ★★★
30 Day Follow-Up—Total	19.77% ★★★	21.78% ★★★	18.68% ★★★	18.40% ★★★	18.88% ★★★
Follow-Up After Emergency Department Visit for Mental Illness[1]					
7-Day Follow-Up—Total	26.03% —	30.51% —	38.97% —	22.71% —	41.80% —
30-Day Follow-Up—Total	40.98% —	47.02% —	58.09% —	39.44% —	59.67% —
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	18.69% ★	35.32% ★★	56.64% ★★★★★	33.83% ★★	39.37% ★★★
30-Day Follow-Up—Total	41.52% ★	53.82% ★★	68.14% ★★★★	48.76% ★	61.32% ★★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	29.73% ★	51.92% ★★★★	74.36% ★★★★★	NA	NA
Continuation and Maintenance Phase	NA	66.67% ★★★★	NA	NA	NA
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness					
Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	27.36% —	36.70% —	18.03% —	44.38% —	42.00% —

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 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, 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.
— 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 all measure rates that could be compared to benchmarks ranking at or above the 50th percentile. Additionally, six of KFHP QI's measure rates ranked at or above the 75th percentile, two of which exceeded the 90th percentile. AlohaCare QI and 'Ohana QI demonstrated the worst performance among the health plans, with each health plan having six of their reportable measure rates falling below the 50th percentile. The health plans demonstrated the best performance on the three *Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—30-Day Follow-Up* measure indicators, with all health plans with reportable rates ranking at or above the 50th percentile for all three indicators. Health plans demonstrated the worst performance for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, with all health plans' rates except KFHP QI falling below the 25th percentile.

Two measures[4-4] within the Care of Chronic Conditions domain were associated with an MQD Quality Strategy target in HEDIS 2019. KFHP QI was the only health plan to meet or exceed the targets for both *Follow-Up After Hospitalization for Mental Illness* indicators.

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 2019 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**	47.78 ★★★★	38.59 ★★★★★	32.97 ★★★★★	62.41 ★★	51.01 ★★★
Outpatient Visits—Total	285.85 —	299.96 —	530.40 —	426.68 —	442.12 —
ED Visits for Ambulatory Care Sensitive Conditions*					
PCP Treatable ED Visits	12.84% —	11.88% —	11.81% —	14.43% —	14.05% —
Preventable/Avoidable ED Visits	68.73% —	69.76% —	68.94% —	64.23% —	65.13% —
Enrollment by Product Line—Total					
0–19 Years Subtotal Percentage—Total	48.74% —	50.62% —	55.63% —	25.86% —	22.23% —
20–44 Years Subtotal Percentage—Total	30.72% —	30.91% —	26.24% —	33.24% —	31.05% —
45–64 Years Subtotal Percentage—Total	16.18% —	16.32% —	15.35% —	27.24% —	24.08% —
65+ Years Subtotal Percentage—Total	4.36% —	2.15% —	2.78% —	13.66% —	22.64% —
Inpatient Utilization—General Hospital/Acute Care—Total					
Maternity—Average Length of Stay—Total	2.67 —	2.53 —	2.32 —	2.56 —	2.81 —
Maternity—Days per 1,000 Member Months—Total	7.21 —	5.76 —	5.39 —	5.26 —	5.60 —
Maternity—Discharges per 1,000 Member Months—Total	2.70 —	2.28 —	2.32 —	2.06 —	1.99 —
Medicine—Average Length of Stay—Total	5.26 —	5.27 —	4.37 —	5.74 —	6.05 —

[4-4] Within this domain, there were two MQD Quality Strategy targets: *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total.*

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Medicine—Days per 1,000 Member Months—Total	16.00 —	10.85 —	8.35 —	44.26 —	35.67 —
Medicine—Discharges per 1,000 Member Months—Total	3.04 —	2.06 —	1.91 —	7.71 —	5.90 —
Surgery—Average Length of Stay—Total	10.44 —	7.25 —	8.85 —	13.41 —	8.84 —
Surgery—Days per 1,000 Member Months—Total	17.76 —	6.37 —	9.25 —	40.27 —	23.63 —
Surgery—Discharges per 1,000 Member Months—Total	1.70 —	0.88 —	1.04 —	3.00 —	2.67 —
Total Inpatient—Average Length of Stay—Total	5.85 —	4.68 —	4.70 —	7.25 —	6.38 —
Total Inpatient—Days per 1,000 Member Months—Total	38.81 —	21.29 —	21.22 —	88.29 —	62.92 —
Total Inpatient—Discharges per 1,000 Member Months—Total	6.63 —	4.55 —	4.52 —	12.18 —	9.86 —
Mental Health Utilization[1]					
Any Service—Total	7.66% —	10.86% —	8.24% —	13.86% —	11.68% —
Inpatient—Total	0.52% —	0.41% —	0.41% —	0.96% —	0.60% —
Intensive Outpatient or Partial Hospitalization—Total	0.08% —	0.05% —	0.10% —	0.66% —	0.48% —
Outpatient—Total	7.37% —	10.65% —	8.17% —	13.31% —	11.22% —
*ED—Total**	0.12% —	0.22% —	0.03% —	0.71% —	0.95% —
Telehealth—Total	0.07% —	0.18% —	0.09% —	0.16% —	0.10% —
Plan All-Cause Readmissions					
*Index Total Stays—Observed Readmissions—Ages 18-44**	10.23% ★★★★★	11.92% ★★★★	12.45% ★★★★	21.79% ★	13.81% ★★★
*Index Total Stays—Observed Readmissions—Ages 45-54**	15.74% ★★★	12.50% ★★★★	12.86% ★★★★	19.07% ★	13.68% ★★★
*Index Total Stays—Observed Readmissions—Ages 55-64**	13.51% ★★★	9.98% ★★★★★	10.29% ★★★★★	18.97% ★	15.34% ★★★
*Index Total Stays—Observed Readmissions—Total**	12.71% ★★★★	11.49% ★★★★	11.89% ★★★★	19.82% ★	14.46% ★★★

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 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, comparisons to benchmarks are not performed for this measure.
— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.

Within the Utilization and Health Plan Descriptive Information performance measure domain, four of five health plans ranked at or above the 50th percentile for *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*. 'Ohana QI was the only health plan that ranked below the 50th percentile. Additionally, four of five health plans ranked at or above the 50th percentile for all four *Plan All-Cause Readmissions* measures, with two health plans ranking at or above the 75th percentile for all four indicators. 'Ohana QI was the only health plan to fall below the 25th percentile for each *Plan All-Cause Readmissions* indicator. HMSA QI and KFHP QI met the target for the *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total* measure.

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 and Target	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Children's Preventive Health					
Childhood Immunization Status—Combination 3 (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Women's Health					
Breast Cancer Screening (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Cervical Cancer Screening (75th Percentile)	Not Met	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	Not Met	Met	Not Met	Met

Measure and Target	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Comprehensive Diabetes Care—HbA1c Control (<8.0%) (50th Percentile)	Not Met	Not Met	Met	Met	Met
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed (75th Percentile)	Not Met	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[1] (75th Percentile)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Medication Management for People With Asthma—Medication Compliance 50%—Total (75th Percentile)	Not Met	Not Met	Not Met	Not Met	Met
Medication Management for People With Asthma—Medication Compliance 75%—Total (75th Percentile)	Not Met	Not Met	Not Met	Not Met	Met
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total (75th Percentile)	Not Met	Not Met	Met	Not Met	Not Met
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	**0**	**2**	**12**	**2**	**5**
Percent MQD Targets Met	**0.00%**	**14.29%**	**85.71%**	**14.29%**	**35.71%**

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 technical specification changes for HEDIS 2019, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for this measure.

All five health plans had reportable rates for the 14 applicable measures with MQD Quality Strategy targets. KFHP QI met or exceeded 12 of 14 (85.7 percent) MQD Quality Strategy targets, followed by UHC CP QI, which met or exceeded the MQD Quality Strategy targets for five of 14 (35.7 percent) measures. HMSA QI and 'Ohana QI each met or exceeded two of 14 (14.3 percent) MQD Quality Strategy targets, while AlohaCare QI met none 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

Table 4-10 summarizes HSAG’s key validation findings for the two PIPs conducted by the QUEST Integration health plans. The key validation findings include whether each PIP achieved its SMART Aim goal and the overall confidence level HSAG assigned to each PIP.

Table 4-10—PIP Validation Findings for the QI Health Plans

Health Plan	Getting Needed Care		Prenatal and Postpartum Care	
	SMART Aim Goal Achieved	Confidence Level	SMART Aim Goal Achieved	Confidence Level
AlohaCare QI	*Yes*	*High Confidence*	*Prenatal–Yes* *Postpartum–No*	*Low Confidence*
HMSA QI	*Yes*	*Low Confidence*	*Prenatal–Yes* *Postpartum–Yes*	*Low Confidence*
‘Ohana QI	*No*	*Low Confidence*	*Prenatal–No* *Postpartum–No*	*Low Confidence*
UHC CP QI	*Yes*	*Reported PIP results were not credible*	*Prenatal–No* *Postpartum–No*	*Low Confidence*
KFHP QI	*Yes*	*Confidence*	Asthma Medication Management *Yes*	*High Confidence*

Table 4-11 summarizes HSAG’s key validation findings for the two PIPs conducted by ‘Ohana CCS.

Table 4-11—PIP Validation Findings for ‘Ohana CCS

	Follow-Up After Hospitalization for Mental Illness		Behavioral Health Assessment	
Health Plan	SMART Aim Goal Achieved	Confidence Level	SMART Aim Goal Achieved	Confidence Level
‘Ohana CCS	*Yes*	*Low Confidence*	*Yes*	*Low Confidence*

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

Statewide Comparisons—QI Health Plans

Table 4-12 presents the 2019 percentage of top-level responses for each QI health plan and the QI Program aggregate.[4-5] Additionally, the QI health plans' results compared to the overall QI Program aggregate are displayed below.

Table 4-12—Comparison of 2019 QUEST Integration Child CAHPS Results

	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	QI Program Aggregate
Global Ratings						
Rating of Health Plan	72.5%	74.1% ↑	71.9%	65.2% ↓	65.9%	70.4%
Rating of All Health Care	68.4%	72.3%	64.5%	61.3%	66.0%	66.9%
Rating of Personal Doctor	76.5%	78.1%	79.3% ↑	74.8%	65.3% ↓	75.6%
Rating of Specialist Seen Most Often	71.7%+	74.5%+	74.7%+	76.3%+	66.7%+	73.0%
Composite Measures						
Getting Needed Care	82.2%	82.0%	81.5%	79.1%	80.2%	81.2%
Getting Care Quickly	85.5%	87.0%	90.4% ↑	79.6% ↓	83.0%	85.5%
How Well Doctors Communicate	91.9%	96.3% ↑	96.2% ↑	91.8%	92.6%	94.2%
Customer Service	87.1%+	86.4%+	88.3%+	80.2%	84.1%+	85.0%
Shared Decision Making	77.2%+	82.6%+	79.6%+	80.9%+	80.9%+	80.3%
Individual Item Measures						
Coordination of Care	81.3%+	80.8%+	84.8%	88.6%+	83.3%+	83.8%
Health Promotion and Education	79.4%	73.4%	79.8%	81.1%	76.6%	77.9%

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 NCQA child 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.

[4-5] 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 2018 NCQA child Medicaid national averages revealed the following summary results:

- The QI Program aggregate scored at or above the national averages on four measures: *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- AlohaCare QI scored at or above the national averages on two measures: *Rating of Health Plan* and *Health Promotion and Education*.
- HMSA QI scored at or above the national averages on seven measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Health Promotion and Education*.
- KFHP QI scored at or above the national averages on eight measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- 'Ohana QI scored at or above the national averages on four measures: *Rating of Specialist Seen Most Often*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- UHC CP QI scored at or above the national averages on three measures: *Shared Decision Making*, *Coordination of Care*, 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 measures.
- HMSA QI scored statistically significantly higher than the QI Program aggregate on two measures: *Rating of Health Plan* and *How Well Doctors Communicate*.
- KFHP QI scored statistically significantly higher than the QI Program aggregate on three measures: *Rating of Personal Doctor*, *Getting Care Quickly*, and *How Well Doctors Communicate*.
- 'Ohana QI scored statistically significantly lower than the QI Program aggregate on two measures: *Rating of Health Plan* and *Getting Care Quickly*.
- UHC CP QI scored statistically significantly lower than the QI Program aggregate on one measure, *Rating of Personal Doctor*.

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

Table 4-13 presents the top-box scores for the Hawaii CHIP population.

Table 4-13—Comparison of 2019 CHIP CAHPS Results

Global Ratings	
Rating of Health Plan	71.4%
Rating of All Health Care	66.4%
Rating of Personal Doctor	77.1%
Rating of Specialist Seen Most Often	67.9%+
Composite Measures	
Getting Needed Care	76.0%
Getting Care Quickly	85.3%
How Well Doctors Communicate	95.8%
Customer Service	84.7%+
Shared Decision Making	75.9%+
Individual Item Measures	
Coordination of Care	91.2%
Health Promotion and Education	75.3%

Cells highlighted in yellow represent scores that are at or above the 2018 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2018 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 2019 scores to the 2018 NCQA child Medicaid national averages revealed the following summary results:

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

NCQA Comparisons—QI Health Plans

Based on the comparison of the QI Program and each of the QI health plans' top-box scores to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data, member experience 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 4-14.[4-6]

Table 4-14—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 4-15 shows the QI Program aggregate's and each participating QI health plan's member experience ratings and top-box scores for each of the four global ratings.

Table 4-15—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	★★ 70.4%	★★ 66.9%	★★ 75.6%	★★ 73.0%
AlohaCare QI	★★★ 72.5%	★★ 68.4%	★★★ 76.5%	★★ 71.7%+
HMSA QI	★★★ 74.1%	★★★ 72.3%	★★★ 78.1%	★★★ 74.5%+
KFHP QI	★★★ 71.9%	★ 64.5%	★★★ 79.3%	★★★ 74.7%+
'Ohana QI	★ 65.2%	★ 61.3%	★★ 74.8%	★★★ 76.3%+
UHC CP QI	★ 65.9%	★ 66.0%	★ 65.3%	★ 66.7%+
+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.				

[4-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018*. Washington, DC: NCQA, September 2018.

Table 4-16 shows the QI Program aggregate's and each participating QI health plan's member experience ratings and top-box scores for each of the five composite measures.

Table 4-16—NCQA Comparisons: Composite Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Shared Decision Making
QI Program	★ 81.2%	★ 85.5%	★★★ 94.2%	★ 85.0%	★★★ 80.3%
AlohaCare QI	★★ 82.2%	★ 85.5%	★ 91.9%	★ 87.1%+	★★ 77.2%+
HMSA QI	★★ 82.0%	★★ 87.0%	★★★★ 96.3%	★ 86.4%+	★★★★ 82.6%+
KFHP QI	★ 81.5%	★★★ 90.4%	★★★★ 96.2%	★★ 88.3%+	★★★ 79.6%+
'Ohana QI	★ 79.1%	★ 79.6%	★ 91.8%	★ 80.2%	★★★ 80.9%+
UHC CP QI	★ 80.2%	★ 83.0%	★★ 92.6%	★ 84.1%+	★★★ 80.9%+
+ Indicates fewer than 100 respondents. Caution should be exercised when interpreting these results.					

Table 4-17 shows the QI Program aggregate's and each participating QI health plan's child member experience ratings on the two individual item measures.

Table 4-17—NCQA Comparisons: Individual Item Measures

Plan Name	Coordination of Care	Health Promotion and Education
QI Program	★★★ 83.8%	★★★★★ 77.9%
AlohaCare QI	★★ 81.3%+	★★★★★ 79.4%
HMSA QI	★★ 80.8%+	★★★ 73.4%
KFHP QI	★★★ 84.8%	★★★★★ 79.8%
'Ohana QI	★★★★★ 88.6%+	★★★★★ 81.1%

Plan Name	Coordination of Care	Health Promotion and Education
UHC CP QI	★★★ 83.3%+	★★★★ 76.6%
+ 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 experience 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' experience 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*.

- None of the QI health plans' member experience ratings met or exceeded the 75th percentile for *Rating of Health Plan*.
- None of the QI health plans' member experience ratings met or exceeded the 75th percentile for *Getting Needed Care*.
- HMSA QI's and KFHP QI's member experience ratings for *How Well Doctors Communicate* met or exceeded the 75th percentile requirement.

NCQA Comparisons—CHIP

Table 4-18 presents the overall member experience ratings and top-box scores for the Hawaii CHIP population on each of the four global ratings, five composite measures, and two individual item measures.[4-7]

Table 4-18—NCQA Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	71.4%	★★★
Rating of All Health Care	66.4%	★
Rating of Personal Doctor	77.1%	★★★
Rating of Specialist Seen Most Often	67.9%+	★
Composite Measures		
Getting Needed Care	76.0%	★
Getting Care Quickly	85.3%	★

[4-7] NCQA's benchmarks for the child Medicaid population were used to derive the overall member experience ratings; therefore, caution should be exercised when interpreting these results.

Measure	Score	Star Rating
How Well Doctors Communicate	95.8%	★★★★
Customer Service	84.7%+	★
Shared Decision Making	75.9%+	★★
Individual Item Measures		
Coordination of Care	91.2%	★★★★★
Health Promotion and Education	75.3%	★★★★

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
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 one measure, *Coordination of Care*.
- The CHIP population scored at or between the 75th and 89th percentiles on two measures: *How Well Doctors Communicate* and *Health Promotion and Education*.
- The CHIP population scored at or between the 50th and 74th percentiles on two measures: *Rating of Health Plan* and *Rating of Personal Doctor*.
- The CHIP population scored at or between the 25th and 49th percentiles on one measure, *Shared Decision Making*.
- The CHIP population scored below the 25th percentile on five measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly, and Customer Service*.

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 (2018) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, and CAHPS. 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 in 2018. KFHP QI completed its remaining CAP items in March 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 2018 technical report did not contain specific recommendations. All health plans worked with HSAG to implement recommended improvements to subsequent PIP submissions.

AlohaCare Quest Integration (AlohaCare QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 NCQA HEDIS Compliance Audit Recommendations

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.

Improvement Activities Implemented

Regarding the integration of behavioral health data from 'Ohana CCS, AlohaCare established a process whereby the claims and encounter data are received quarterly. These data are processed through our certified HEDIS vendor, Inovalon, through interfaces designed in Inovalon's systems, as well as our internal reporting queries. This allows for ongoing evaluation and monitoring of any related metrics as a part of standard reporting tools. Additionally, AlohaCare expects that reporting of behavioral health related metrics will improve for the next reporting period.

AlohaCare has been working with Inovalon and our corporate HEDIS auditor (Advent Advisory Group) on HEDIS throughout the summer to prepare for the next HEDIS season and to ensure accurate and timely delivery of tasks such as measure calculation, hybrid sample selection, and other medical record review related tasks. The early intervention of our HEDIS schedule also includes monthly proactive rate trending to anticipate exclusion counts and evaluation of oversample populations. Additionally, AlohaCare staff will attend Advent Advisory Group's HEDIS conference to receive training on changes in HEDIS 2020 requirements and identify opportunities for efficiencies. AlohaCare will continue to use internal reporting for Hawaii State measures *Emergency Department Visits for Ambulatory Care-Sensitive Condition* (*NYU)* and *Follow-Up With a Primary Care Practitioner (PCP) After Hospitalization for Mental Illness* (*FUP)*.

2018 HEDIS Performance Measure 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*

Improvement Activities Implemented

The plan identified several barriers to improved HEDIS performance in reporting year 2017 and in response, implemented several interventions throughout 2018. The aggregate success of these

interventions did make a positive impact on HEDIS measure rates, but the plan does recognize that 39 measures still rank below the 50th percentile, with 32 of these measures ranking below the 25th percentile. Overall the planned improvement activities included the continued progress of several of the interventions implemented in 2018 as well as the evaluation of additional interventions.

Continued Interventions

Pay for Performance Program (P4P): AlohaCare will continue to evaluate and improve the structure, administration, and participation of the P4P program to maximize effectiveness. The P4P program will be diligently communicated to network providers and will be supported through routine coordinated meetings by Quality Improvement staff to provide education and feedback on performance.

Quality Improvement Department Structure: The infrastructure changes to the Quality Improvement department were completed in 2018 with the establishment of the Quality Improvement Teams (QITs). The QITs were established 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 functional departments. The membership on QITs is cross-functional. QITs use rapid-cycle improvement 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.

Additionally, a provider-facing team was established in 2018 and is managed by the QI performance accountability manager and includes a team of QI review nurses to coach the Community Health Centers and PCPs with panels of 50 members or greater. The focus of this team is to furnish training and feedback regarding closing gaps in care, use of the Health Catalyst reports to target members for outreach, and encourage participation in the P4P incentive program. This team has strict performance expectations and have both face-to-face and telephonic meetings on all the islands.

Gaps in Care (GIC) Lists: The plan successfully implemented and rolled out the use of GIC lists in September 2018. The GIC data are produced from the newly implemented data warehouse, Health Catalyst. The QI nurses on the provider-facing team are now meeting in person or by telephone with all PCPs who have panels of greater than 50 members to deliver and encourage use of the GIC reports. Providers are requesting the ability to see their own compliance in a scorecard format and allow for the comparison to performance of peers. This is the next phase of the intervention which is planned for Q4 2019.

New Model of Care & Care Coordination: The plan implemented a new model of care in 2018 with a focus on:

- Integration of care across Medicare and Medicaid (80 percent of special needs plan [SNP] members are dually enrolled in AlohaCare QI).
- Addressing long-term service needs in addition to acute care needs.
- Coordination of needs across physical, behavioral, and social health services including addressing the impact of social determinants of health (SDoH).

- Proactive identification of members at risk for future healthcare episodes and coordination of preventive interventions.

In early 2019, a focus on gaps in care specific to HEDIS and other preventive care measures was added to the model of care. The next phase of this intervention is the integration of GIC data from Health Catalyst into the new case management and medical records system, Guiding Care (G8).

Digital Outreach Campaigns: In 2018 the Population Health—Quality Improvement Department contracted with HealthCrowd to implement a digital outreach program with the Unified Communications Platform. The platform coordinated the use of multiple digital modalities including SMS text and multiple-level interactive voice response (IVR) phone calls, depending on the modality that is most appropriate and works best for each member. The focus for 2018 campaigns included:

- Well-care visits for children and adolescents
- Childhood immunizations
- Prenatal and postpartum care
- Diabetes care

The plan will continue to evaluate the effectiveness of this intervention and will evaluate the potential use for additional measures.

Potential Additional Interventions

Member Wellness Programs and Incentives: The plan will evaluate the use of programs designed to promote preventive services through incentives. The plan is currently evaluating evidence-based programs with proven effectiveness.

Community/Home-Based Practitioner Visits: The plan will evaluate the use of mobile practitioners, including physicians and nurse practitioners, to visit members in the community setting. This intervention will improve access to preventive services when access is a barrier. Additionally, this intervention will be evaluated to close gaps in care in the homeless population.

CAHPS—Adult Survey

2018 Recommendations

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.*

Improvement Activities Implemented

In accordance with the AlohaCare QAPI Program and workplan, the CAHPS survey outcomes were presented to the Corporate Quality Improvement Committee (CQIC) in June 2019. During that

presentation, the CAHPS Survey evaluation also identified *Getting Care Quickly, Getting Needed Care* and *Coordination of Care* as potential areas of quality improvement and recommended the following:

1. Obtain a current population based on the DSS survey methodology by July 31, 2019.
2. Use this population to determine the following sub-populations by July 31, 2019:
   a. Members with primary care visits
   b. Members with specialist visits
      i. Number of specialist visits
      ii. Specialists
   c. Members with an assigned care coordinator or service coordinator
   d. Members with authorizations for services
3. Using the population, conduct mini-surveys through outreach to determine satisfaction with related processes and identify potential issues by October 31, 2019.
4. Report findings and determine any opportunities for improvement to the following CQIC meeting.

Additionally, individuals representing oversight for Quality Improvement, Provider Services, Utilization Management, and Care Coordination were assigned to identify potential areas for improvement and report back to CQIC. The CQIC will continue to monitor the progress of the interventions and any identified opportunities.

Provider Survey

2018 Recommendations

Based on the survey results, AlohaCare QI should focus efforts on improving the following three measures which scored statistically significantly lower than the QI Program aggregate:

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

Improvement Activities Implemented

The outcomes of the Provider Survey were presented to the CQIC in August. Recommendations were made by the CQIC to evaluate and develop activities to improve any measure rate that was lower than the QI Program aggregate in the plan comparison.

Activities to improve provider satisfaction with access to non-formulary drugs: The Clinical Pharmacy Department monitors prior authorization (PA) requests for PA required and non-formulary agents quarterly as part of the functions of the Pharmacy and Therapeutics (P&T) Committee meeting. For drugs with a high percentage of approval, the plan will either add these drugs to the formulary or require

a step therapy to alleviate the unnecessary PA request by providers. Quarterly, the Clinical Pharmacy Department will assess its PA program to ensure appropriate access to therapy. Medications that have a high approval rate are evaluated for potential addition to the formulary.

Activities to improve provider satisfaction with adequacy of specialists: The Provider Network department monitors physician-to-member ratios, geo-access time and distance, and provider counts for each specialty by island for compliance with reporting to Hawaii DHS, and for internal network development planning. For communities on each island where AlohaCare does not have a contracted local provider in a given specialty, or there is a lack of choice of providers in that specialty, AlohaCare will contact and offer contracts to specialists practicing in the community that are not currently participating in network with AlohaCare. Good faith efforts to contract will be documented in the Network Development tracking tool, with the result (e.g., contract executed, provider declined) also documented. If there are no providers of a given specialty practicing in that community, AlohaCare will document the absence of availability for that specialty and document our process for arranging for services in that specialty (e.g., travel arrangements for members to the nearest contracted or out-of-network provider in that specialty; arrange for contracted specialists from another community or island to travel to the community with an absence of that specialty; or in some circumstances, provide telemedicine access to that specialty). AlohaCare will ensure that PCPs are aware of what specialists are participating in our network by distributing a current listing of our specialty network through multiple communication methods (e.g., fax, email, provider website, newsletter, and site visits to primary care offices). These communications will also describe how PCPs can obtain assistance from AlohaCare in locating a given specialist when they need to refer members for specialty care.

Activities to improve provider satisfaction with adequacy of behavioral health specialists: The Provider Network department monitors behavioral health provider-to member ratios, geo-access time and distance, and behavioral health provider counts for each behavioral health specialty by island for compliance with reporting to Hawaii DHS, and for internal Network Development planning. For communities on each island where AlohaCare does not have a contracted local behavioral health specialist, or there is a lack of choice of behavioral health specialists, AlohaCare will contact and offer contracts to behavioral health specialists practicing in the community that are not currently participating in network with AlohaCare. Good faith efforts to contract will be documented in the Network Development tracking tool, with the result (e.g., contract executed, provider declined) also documented. If there are no behavioral health specialists practicing in that community, AlohaCare will document the absence of availability and document our process for arranging for these services (e.g., travel arrangements for members to the nearest contracted or out-of-network provider; arrange for contracted behavioral health specialists from another community or island to travel to the community with an absence of behavioral health specialists; or in some circumstances, provide telemedicine access for specialty behavioral health). AlohaCare will ensure that PCPs are aware of what behavioral health specialists are participating in our network by distributing a current listing of our behavioral health specialists through multiple communication methods (e.g., fax, email, provider website, newsletter, and site visits to primary care offices). These communications will also describe how PCPs can obtain assistance from AlohaCare in locating a behavioral health specialist when they need to refer members for specialty behavioral health services.

HMSA Quest Integration (HMSA QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 NCQA HEDIS Compliance Audit Recommendations

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.

Improvement Activities Implemented

The HEDIS 2018 Compliance Audit recommendation was based on the *CDC HbA1c Control <7%* minimum required sample size (MRSS) not being met because the oversample was not large enough to cover the amount of required exclusions removed from the hybrid sample.

To address the audit recommendation, HMSA QI modified its process to evaluate the number of exclusions and oversamples after each administrative data refresh and medical record review portable database synchronization. Previously, the evaluation was performed only once following the conclusion of medical record reviews.

The process involves the Cotiviti Quality Reporter application's Activate Oversample Records to Meet MRSS feature which identifies and inserts necessary substitutions from the oversample lists into the applicable sample populations when activated. When activating oversamples for *CDC HbA1c Control <7%* exclusions, the feature increases the denominator for all numerators until the <7% denominator is 411 or there are no more oversample members available. Should the number of remaining oversamples for a measure reach a specified minimum threshold greater than zero, HMSA QI will notify the auditor and consult on next steps to ensure MRSS is met.

The updated process was successfully implemented with no MRSS issues in HEDIS 2019.

2018 HEDIS Performance Measure 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, body mass index (BMI) percentile documentation for children and adolescents, follow-up treatment for children after ED visits for alcohol and other drugs (AOD) abuse or dependence, follow-up care for children prescribed attention deficit hyperactivity disorder (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*

Improvement Activities Implemented

Adult Access to Care

HMSA's Online Care (HOC) offers members an alternative source to care with 24/7 telephone or Web access to providers. HOC continues to expand and provides innovative services to members, including offering Web consultations or follow-up appointments for certain specialties.

Another option available to members that improves access to care is having urgent care providers located in clinics on Oahu, Maui, Hawaii Island, and Kauai. The urgent care clinics offer extended weekday hours, weekend and holiday hours, and can treat a wide range of conditions, except life-threatening emergencies.

In addition, HMSA continues to provide member education materials, such as articles in our quarterly member magazine or newsletters specific to lines of business, to increase member awareness of care options and to help members understand their role in obtaining appropriate, timely care.

Adolescent Preventive Care

HMSA has two programs, Payment Transformation and federally qualified health center (FQHC) Pay-for-Quality, in which part of a physician's compensation is tied to specific quality metrics. This shifts the physician incentive from volume to value.

HMSA's quality payment programs have historically included (and continue to include) a measure for adolescent immunizations which encompasses Tdap, meningococcal, and Gardasil.

Women's Health

HMSA has two programs, Payment Transformation and FQHC Pay-for-Quality, in which part of a physician's compensation is tied to specific quality metrics. This shifts the physician incentive from volume to value.

HMSA's quality payment programs have historically included (and continues to include) a measure for *Chlamydia Screening in Women*.

Pregnancy Support Program: The program pairs pregnant members with a maternity registered nurse (RN) for telephonic education and referrals. RN support is intended to complement and encourage regular prenatal and postpartum care. The program RN maintains contact with the member from enrollment through the first month after delivery.

The QUEST performance improvement initiative was developed to improve outreach to QUEST members. The Pregnancy Support Program is working with participating FQHCs to identify newly diagnosed pregnant members and offer additional resources.

Pregnancy Support program advertisements are included in the summer and winter issues of the HMSA published *Island Scene Magazine* available at https://islandscene.com.

Care for Chronic Conditions

Informational themed mailings directed at a topic related to the condition was mailed to members and posted to the provider resource center for providers who wish to distribute Well-Being Resource program support materials to their patients. Members identified in groups 2 and 3 were referred to SRMs, CareFinder, special health care needs (SHCN), and Integrated Health Management Services (IHMS).

Behavioral Health

The Quality Management Program collaborates with other functional areas to ensure members have a high quality of life. This is done through health promotion, coordination of care across all settings, and using clinical practice guidelines to improve the overall wellness of our membership. Beacon used 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 primary activities entailed provider and member education surrounding HEDIS behavioral health measures and 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 offered to providers as a resource to consult with a Beacon board-certified psychiatrist. While HMSA has a pharmacy advisor program benefit for its commercial and QUEST members, Beacon explored supplemental activities to implement that would not overlap with the program's activities.

Beacon continued its local Aftercare program. The goal of the program is to ensure that a follow-up appointment is scheduled and kept within seven days of discharge, by working closely with the discharging facility, member, and outpatient behavioral health provider. Additionally, Beacon launched a pilot that offers face-to-face Aftercare support at discharging facilities. To maximize end-of-year HEDIS rates, supplemental data are collected for confirmed "kept" appointments through the Aftercare program.

Beacon adopted the Transition of Care (TOC) model. This model uses Beacon staff to perform the post-discharge care within seven days of discharge. A service coordinator will conduct a telephonic appointment with the member within two business days of discharge. During the member communication, the service coordinator will contact the member and discuss the importance of medication and treatment adherence and discharge instructions, any laboratory tests that are required, community resources, and self-management techniques. Supplemental data will be submitted to demonstrate *FUH* compliance.

Provider engagement focuses on education and interventions in place to promote the importance of Aftercare and best practices of the HEDIS *FUH* measure. Facility visits are conducted quarterly throughout the year. During these visits, Beacon encourages that facility discharge planning begin at the start of admission and that scheduling of Aftercare appointments should be accomplished (by the facility) prior to discharge. Effective and timely discharge planning ensures continuous and coordinated behavioral healthcare treatment for patients following discharge from an acute care facility. Outpatient follow-up care with a behavioral health provider after inpatient admissions can provide the necessary continuity of care that people with acute and chronic mental health disorders require. Outpatient follow-up care also supports a patient's return to baseline functioning in a less restrictive level of care.

CAHPS—Adult Survey

2018 Recommendations

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.*

Improvement Activities Implemented

Getting Needed Care—To simplify and streamline the referral process and to ensure that members have access to care when they need it, HMSA revised its referral process for specialty care. Beginning in January 2015, PCPs only need to register referrals with HMSA for off-island specialty care, referrals to nonparticipating providers, plastic surgery, rehabilitation services, and dermatology services. Although a registered referral is no longer required, PCPs and specialists must still keep records of referral in their patient record.

Getting Care Quickly—Providers are encouraged to open scheduling and provide additional ways for members to access a care team through telephone, secure electronic messaging, or other means. HMSA provides a 24-hour nurse advice line that members can call to talk with a nurse, answer questions, and determine whether a member should see a doctor or go to the emergency room. HMSA's 24-hour nurse advice line can also refer a member to a participating provider. For members that are chronic no-shows, providers have the option of referring the member for service coordination. The service coordinator assigned to the member will assist with identifying barriers, developing a service plan, and coordinating services that will support the member's needs and reduce no-shows.

Coordination of Care—PCPs are reminded about the importance of effective doctor-patient communication to continually discuss and review clinical needs and coordination of care between specialists, and other providers managing the care of the member. HMSA will routinely provide updates and reminders via HMSA's monthly provider newsletter to the providers to ensure coordination of care for our members.

Provider Survey

2018 Recommendations

Based on the survey results, HMSA QI should focus efforts on improving the following measure which scored statistically significantly lower than the QI Program aggregate:

- *Adequate Access to Non-Formulary Drugs*

Improvement Activities Implemented

The HMSA QUEST Integration Formulary is based on scientific evidence, standards of practice, peer-reviewed medical literature, and accepted clinical practice guidelines. The formulary is managed, drives generic use, uses over-the-counter products, and is customized to meet the clinical needs of HMSA's QUEST Integration membership and local prescribing patterns. The formulary is fortified with select brand drugs, which have been determined to be medically necessary when equivalent generic drugs are not available, or the brand drug offers better therapeutic outcomes or a more favorable safety profile.

HMSA has implemented the following programs to improve access to non-formulary drugs:

- In 2019, HMSA updated the QUEST Integration Non-Formulary Exceptions Criteria located at: https://hmsa.com/portal/PROVIDER/CVS_Formulary_Exception_PA_Form_QUEST_Integration.pdf.
  - Extended the approval duration for generic non-formulary medications from 12 months to 36 months.
  - Non-formulary medications that do not have therapeutic formulary alternatives will be approved.
  - Allow an exceptions review for certain types of controlled substances (e.g., Epidiolex).
  - All PA requests are approved or denied within 24 hours of receipt.
- Providers can request a non-formulary medication be added to the HMSA QUEST Integration Formulary if it offers a distinct clinical advantage over medications on the formulary. The application form is located at: https://hmsa.com/portal/PROVIDER/Application_for_Formulary_Review.pdf.
  - In 2019, HMSA added six medications (Crinone gel, Chemet, pentoxifylline, Vitamin E, atropine, and Lotemax gel) to the QUEST Integration Formulary as a result of feedback obtained from the local provider community.
- HMSA established a pharmacy prior authorization workgroup that monitors and analyzes the prior authorization process for areas of opportunities to improve member and provider experiences. Clinical pharmacists provide recommendations for formulary and utilization management opportunities based on trends seen by routinely monitoring prior authorization reports and appeal decisions.

HMSA also has a Prior Authorization process for providers that simplifies and minimizes administrative burdens. This includes Electronic Prior Authorization, Smart PA program, Real Time Benefits etc. These processes assist providers with access to non-formulary drugs, and additional information about the processes is available on request.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 HEDIS Performance Measure 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*

Improvement Activities Implemented

The following table depicts the three-year trend results for the *Medication Management for People with Asthma* measure recommended for improvement. HEDIS 2019 results indicate that improvement was achieved during 2018 measurement.

	HEDIS 2017 Rate	HEDIS 2018 Rate	HEDIS 2019 Rate
Medication Management for People With Asthma (mma)			
Total Medication Compliance 50%	42.02%	48.89%	58.85%

An evaluation of the barriers and the activities implemented as part of our quality improvement process is also outlined as follows:

Continued improvement has been seen in the 50 percent compliance rate.

Barriers: The specifications for this measure are complex which makes it very difficult to obtain the data needed to create an actionable report of noncompliant members.

Activities:

- The quality initiative of clinical pharmacists and specialists targeting patients who were not compliant or at target was continued.
- 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 versus rescue inhaler, timeliness of refills, proper use of device, and general asthma education.
- MD specialists performed chart reviews and sent notices to PCPs to educate members regarding asthma management.

CAHPS—Adult Survey

2018 Recommendations

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.*

Improvement Activities Implemented

Getting Care Quickly and Getting Needed Care

The 2018 results for the areas of *Getting Care Quickly* and *Getting Needed Care* remain flat with no statistically significant changes compared to our 2016 results. The following improvement activities are currently being worked on to address these areas.

- **Appointment Call Center**
  - Improvements to streamline the appointment call center process and member experience.
- **Online Appointment Booking**

  Kaiser Permanente Hawaii has added specialty departments that allow online appointment booking, making it easier for members to obtain care. Currently, the following appointments are always available for online booking:
  - Primary care same day
  - Cosmetic services
  - Eye care services
  - Hearing aid services
  - Physical therapy

- Sports medicine
- Knee and hip replacement classes
- Weight management information sessions

Also available for online booking with criteria:

- Mammograms and Well Woman physicals—only displays to women and can only be scheduled once a year
- Allergy consults—only display to patients who have NOT had an allergy appointment within 18 months
- Medicare Wellness—only displays to patients 65 and older
- Cataract consults
- Bariatric surgery follow-ups

Coordination of Care

Although there was a slight increase in the 2018 results for the area of Coordination of Care as compared to 2016, the increase was not statistically significant. The following improvement activities are currently being worked on to address this area:

- Service coordinator, in collaboration with PCPs and the Health Care Team, provides oversight of member care coordination across the continuum of services.
- Continuous Health Care Team education and process improvement of the service coordinator's role in order to improve the care coordination process and the member's experience.

Provider Survey

2018 Recommendations

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

Improvement Activities Implemented

Not applicable.

'Ohana Health Plan QUEST Integration ('Ohana QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 NCQA HEDIS Compliance Audit Recommendations

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.

Improvement Activities Implemented

Wellcare and Ohana's HEDIS Team and IT team will ensure close review of each data source submitted in Section 5 and validate applicability to the HI Market prior to submission to ensure accurate Roadmap documentation is provided. Additionally, the Quality Data Analytics and Reporting (QDAR) HEDIS Team will run impact reports on each source in advance to identify measures that would be affected by each supplemental data source.

2018 HEDIS Performance Measure 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 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*

Improvement Activities Implemented

The following improvement activities were implemented to address multiple measures/domains of care:

2019 Medicaid Partnership for Quality (P4Q) Program

- Ohana's 2019 Medicaid Partnership for Quality (P4Q) recognizes providers who collaborate with Ohana to deliver high-quality care. Through the P4Q program, providers are able to obtain financial incentives to close care gaps for eight HEDIS measures including *Adolescent Well-Care Visits; Cervical Cancer Screening; Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *HbA1c Testing; Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care;* and *Well-Child Visits in the First 15 Months of Life* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. Ohana supports providers by working to educate them about the program, in-person delivery by quality practice advisors (QPAs) of current member/measure-specific quality Care Gap Reports (also available via the provider portal), reaching out to members on behalf of the provider to schedule appointments/discuss care needs, and providing general educating on coding and standards of care.
- For the second half of 2019 (July 15–December 31), providers can earn an additional $10 in addition to the current amount per measure for closing care gaps for *Comprehensive Diabetes Care—HbA1C Testing* and *HbA1c Control (<8.0%);* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

2019 Healthy Rewards

- The Ohana Healthy Rewards program incents members and encourages them to take care of their health by providing Visa debit cards, gift cards and/or Bonus Rewards (for completion of multiple visits or services). This program incents members to complete visits touching on 11 HEDIS

measures and also includes an annual adult health screening. HEDIS measures that are incented include *Well-Child Visits in the First 15 Months of Life; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care; Comprehensive Diabetes Care—HbA1C Testing, HbA1c Control (<8.0%),* and *Blood Pressure Control (<140/90 mm Hg); Cervical Cancer Screening; Breast Cancer Screening; Chlamydia Screening;* and behavioral health follow-up measures.

Preventive Care Outreach—Unable to Contact

- Ohana's patient care advocates (PCAs) provide outbound calls to members to encourage them to make or to help schedule an appointment with their primary care provider to address preventive care services. When the PCA is unable to contact members by phone after multiple attempts, unable to contact letters for established patients are sent that identify services which are overdue (including Annual Wellness Visit, Breast Cancer Screening, Well-Woman Exam, Colorectal Cancer Screening, Well-Child Visit, and Immunizations) and asking members to contact their PCP (name and phone number included in the letter). The letter also includes information regarding how to schedule transportation and the PCA's phone number to call if the member needs help scheduling an appointment. A similar letter is sent to members who have an assigned PCP but have not yet established care with that assigned PCP. The letter also provides members with information regarding how to change their PCP if needed.

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*

Improvement Activities Implemented in 2019:

- Ohana promotes access to care for children, adolescents, and adults by encouraging annual wellness visits; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visits; and well-care and well-child visits in accordance with specified age groups and time frames. This is completed via member and provider education as well as member and provider incentives throughout the year.

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

Improvement Activities Implemented in 2019:

- Birthday cards are sent to pediatric and adolescent members turning 1 to 20, a month in advance of their birthday month as a reminder to go into their primary care physician's office for a well-child visit and to inform them of the importance of a well-child visit.
- Reminder letters are sent to pediatric and adolescent members with upcoming birthdays in a month turning 1 to 20 that have not had a visit to see their primary care physician's office for a well-child visit. The reminder letter informs the parents/guardians on the importance of a well-child visit and what to expect in the visit.
- Periodicity letters are sent to remind parents/guardians to schedule well-visits and keep up to date with immunizations for their child.
- Patient care advocates (PCAs), care gap coordinators (CGCs), and service coordinators (SCs) are outreaching to parents/guardians of pediatric members to educate and assist with scheduling appointments for well visits and to obtain missing immunizations.
- Healthy Rewards for well-child visits in the third, fourth, fifth, and sixth years of life. Parents/guardians are given the option on a $25 Visa debit card or gift card for taking their children in for a well-child visit.
- New well-child visit flyers for parents/guardians with information on when well-child visits are recommended, what a well-child visit entails, how a sports physical can be done with a well-child visit, and transportation availability and information.
- Quality practice advisers (QPAs) and/or PCAs provide providers with noncompliant member lists.
- Providers are mailed noncompliant member lists for members not seen for more than 120 days.
- A P4Q Program Enhancement Bonus is offered for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* (additional $10 per gap closed in addition to the $35 that is currently part of P4Q).

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*

Improvement Activities Implemented in 2019:

- Prenatal and postpartum member outreach via Ohana care gap coordinators
- Healthy Rewards Program: $25 for prenatal, postpartum and chlamydia screening
- Bonus Rewards for PPC: Choice of stroller, car seat, playpen, or diapers upon completion of a prenatal and postpartum care visit
- Disease management outreach to high-risk pregnant members

Care for Chronic Conditions

Comprehensive Diabetes Care—HbA1c Control (<7.0%)

Improvement Activities Implemented in 2019:

- QPA/PCA provider and member care gap education
- Healthy Rewards Program
- Lab data/contracts
- CVS Health Tags
- Disease Management Program member outreach for poor-controlled HbA1c
- P4Q Program Enhancement Bonus offered for *Comprehensive Diabetes Care—HbA1C Testing* and *HbA1c Control (<8.0%)* (additional $10 per measure/gap closed in addition to $30 and $20, respectively)

Behavioral Health

Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up

Improvement Activities Implemented in 2019:

- Care gap coordinators outreach to members to facilitate follow-up appointments within seven days of discharge.
- Ohana has contracted with a licensed mental health counselor to perform face-to-face visits with the member to perform follow-up within seven days of discharge from two of the main facilities on Oahu.
- Behavioral health follow-up appointment available via MD Live functionality (telehealth).

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

- Pharmacy team created an educational flyer for the providers to deliver the information on the best practice for members who are taking antipsychotic medications to obtain diabetes screening annually.
- Pharmacy team also visited behavioral health (BH) and PCP offices to discuss the importance of diabetes screenings/monitoring for members taking antipsychotic medication.
- QPAs provide education and trainings on quality-related services for PCPs and have made efforts to connect with all BH providers (psychiatrists, advanced registered nurse practitioners (ARNPs), and physician assistants) in the market. Then, QPAs provided an educational flyer specifically on diabetes screenings for people taking antipsychotic medication and provided guidance on best coding practices when billing.

CAHPS—Adult Survey

2018 Recommendations

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*.

Improvement Activities Implemented

Coordination of Care

Transition Management Coordination Program (TMC)

- Through the TMC Program, initial assessments are conducted within 24 hours of referral to the program for members who have had an inpatient admission. The program's target population are members who remain in a hospital setting post-acute level of care and/or who are inpatient but have been readmitted within 30 days of discharge date or hospitalized at least four times in the past 12 months. Enrolled members receive in-person service coordination for as long as they remain inpatient and as frequently as needed to address problematic discharge barriers. In addition, the program provides telephonic and/or in-person case management up to 30 days post-discharge to prevent readmission.
- The TMC Program's primary focus is to coordinate timely and safe transition of members from a hospital setting to the next stage of care; prevent readmission; and build strong, meaningful relationship with the hospital's discharge planning team. The program addresses discharge barriers such as unsafe home environment; psychosocial behavior, cognitive issues, poor availability of foster home and/or nursing facility beds, lack or absence of caregiver; unpreparedness of family to care for member; and absence of necessary equipment, supplies, and/or resources at the member's home. The TMC Program mitigates readmission risk by promoting effective communication and coordination across the care continuum.

Getting Care Quickly

- Ohana has updated the Access to Care process to ensure timely resolution to access to care issues. Customer service representative agents will call a minimum of three providers to see if they can see the patient within the required time frames. If they are unsuccessful, they will escalate the issue to our offline team who will continue to call providers until they are able to successfully get the member scheduled with a provider within the required time frames.
  - Empowered agents to work directly with the member's PCP. If we do not have the needed specialist on the member's home island, the agent will work with the member's PCP to initiate a travel request so the member can be seen on a neighbor island.
  - Provider Services continues to focus on network adequacy and expansion to assure the availability of PCPs across the State.

  - Reference cards reflecting Ohana appointment accessibility standards have been distributed to PCP offices. Mousepads are in development for distribution in the fourth quarter of 2019.
  - Continue to work with providers to determine what we can do to support providers opening their panels.

Customer Service

- All agents completed the Uplifting Service Training to improve the overall experience for our members and providers who call into the call center.
- Created and or updated call tools as process flows were added or changed. Provided training to staff on these new or updated call tools.
- Ongoing training at department meetings and morning huddles.
- Implemented creative ways to help make learning of important information needed fun and engaging including:
  - Created a crossword activity to help reinforce the correct answers to pharmacy questions and where to find them.
  - Testing and Reinforcing the Importance of CAHPS Crossword Puzzle.
  - Reinforcing the Importance of CAHPS Department Presentation and Word Search activity.
  - March Knowledge Check—Word Search: Created a word search with words that the agents deal with daily while on calls. It was a two-part question sheet where the answer to the question is the word you would search for.
  - Call-Taking BINGO: We played BINGO using caller types, over-the-counter (OTC) items, call drivers, and the Ohana Mobile App to have the agents be familiarized with topics.
  - Pop Quiz: Created a pop quiz of 15 questions regarding the Health Insurance Portability and Accountability Act (HIPAA), call drivers, and call tools.
  - Operation Man Brain Teaser: We made a worksheet of the Operation man [based on Hasbro's Operation board game], and the agents had to figure out which specialist would be able to assist with the body part issue.
  - Shining Stars Call Award for providing Shining Star Service to members and/or providers.

Provider Survey

2018 Recommendations

Based on the survey results, 'Ohana QI should focus efforts on improving the following measures which 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*

Improvement Activities Implemented

Compensation Satisfaction

- We address compensation concerns with our participating providers for network adequacy purposes and to strengthen our network. For example, in 2019 we renegotiated rates with a key pediatric practice and a custom wheelchair provider. We also established a contract with a key specialty surgeon at higher rates. In addition, all of our PCPs have the opportunity to earn additional payments through our pay for quality (P4Q) program that encourages providers to close a wide array of care gaps.

Timeliness of Claims Payments

- We made a number of successful changes to our claims processing approach in order to speed up claims payments. Our average claims turnaround time (TAT) decreased from 10.7 days in January 2019 to 6.5 days in August. In addition, 94 percent of claims had a TAT of 10 days or less in August, as compared to 70.5 percent of claims in January.

Prior Authorization Process

- In 2018 we removed prior authorization requirements for close to 14,000 services. In 2019, we evaluated some services for which we continued to require prior authorizations (PA) and modified some of those requirements. For example, we removed PA requirements for psychotherapy services after a certain number of visits had occurred and are instead monitoring claims for outlier utilization. We continue to evaluate services for which post-utilization review makes more sense than requiring a PA.

Formulary

- We update our formulary on a quarterly basis when we usually add more drugs than remove.

Adequate Access to Non-Formulary Drugs

- We have a user-friendly prior authorization process for non-formulary drugs. Our staff will meet face-to-face with providers to help remove any barriers for these providers when clinical judgement establishes medical necessity.

Adequacy of Specialists

- Hawai'i struggles with a shortage of certain specialists, particularly on the neighbor islands. We continually work to identify and contract with additional specialists across the islands. We reach out to certain providers time and again, attempting to find a way to contract with them. We are currently conducting phone outreach to our PCPs to attempt to identify specialty types and specific specialists that they have had difficulty referring our members to so that we can focus on recruiting these providers to our network.

Adequacy of Behavioral Health Specialists

- Hawai'i also experiences shortages of behavioral health providers, in particular psychiatrists who do not want to contract with Quest Integration MCOs. In mid-May of this year, we initiated a telehealth service, MDLive, that offers behavioral health services and has two psychiatrists and two counselors on its Hawai'i roster. We are informing our PCPs and our members about the availability of MDLive. Through August, 7 behavioral health sessions had occurred.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 HEDIS Performance Measure 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*

Improvement Activities Implemented

The following activities were implemented by the UnitedHealthcare Community Plan Hawai'i (UHC CP HI) in 2019 to address HEDIS measures that fell below the national Medicaid 25th percentile in 2018:

- **Access to Care**
  - *Adults' Access to Preventive/Ambulatory Health Services (AAP)—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*
    - In the current Member Handbook, members are informed of the time frames within which they can expect to get an appointment for primary care services, as well as for specialty and behavioral health (BH) services.
    - In the Summer 2019 Member Newsletter, an article titled, "Wait No More," listed the appointment time frames within which members could expect to be seen for routine, emergency, urgent, specialty, and BH care, for both children and adults.
    - In 2019, UHC CP QI transitioned the Health Disparities Action Plan, which addressed some of the barriers for *AAP*, to widen the scope of addressing and reducing healthcare disparities by proceeding with the NCQA Multicultural Healthcare (MHC) distinction process. The MHC distinction survey submission was completed on September 23, 2019.
    - In 2019, through the Advocate4Me delivery model, customer service advocates (CSAs) continued to assist members with urgent and nonurgent appointment scheduling and facilitating transportation services. CSAs also help connect members to service coordinators and interpreter services when needed.
    - Through the Appointment Setting Campaign, CSAs are alerted if a member is due for preventive care or other important healthcare visits. In May and July 2019, trainings to

Member Services staff included information on a proactive preventive care monitoring process: Rather than relying only on alerts that appear on each call, CSAs proactively review preventive care claims activity on every call to identify any care gaps, hold gap conversations, and offer to schedule appointments. This topic will be on the planned agenda for new hire training classes.

- UHC CP QI is participating in the 2019 Member Rewards Program (MRP), which incentivizes members with a $25 gift card to Walmart or CVS to complete primary care/preventive care visits, including well-child (3–6 years old) and adolescent (12–21 years old) well-care visits, cervical cancer screening, and postpartum care. The gift card amount increased from $10 in the 2018 MRP.
- Clinical practice consultants (CPCs) from the UHC CP QI Quality Team established and developed relationships with OB/GYNs [obstetricians/gynecologists] and pediatricians through engagement in the Community Plan—Primary Care Professional Incentive (CP-PCPi) program, which offers bonuses to providers for closing care opportunities with their members. These care opportunities target preventive services, such as well-child and adolescent well-care visits, childhood immunization, cervical cancer screening, timely prenatal and postpartum care, and HbA1c screening.
- A 2019 Interactive Voice Response (IVR) outreach call campaign to members is being conducted by Silverlink/Welltok to provide education and reminders, and to address the *AAP* measure.

- **Children's Preventive Health**
  - *Childhood Immunization Status (CIS)—Combination 3*, *DTaP*, *Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate*, and *VZV*
  - *Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap)*, *Meningococcal*, and *Tdap*
  - *Well-Child Visits in the First 15 Months of Life (W15)—No Well-Child Visits*
  - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*
    - UHC CP QI is participating in the 2019 Member Rewards Program (MRP), which incentivizes members with a $25 gift card to Walmart or CVS to complete *W34* and adolescent well-care (*AWC*) visits. The gift card amount increased from $10 in the 2018 MRP.
    - UHC CP QI participated in the UnitedHealthcare Baby Blocks program, which is a web-based mobile tool that allows eligible members to earn rewards for attending and tracking well-child care visits for children up to 15 months old.
    - Quality CPCs established and developed relationships with pediatricians through engagement in the CP-PCPi program, which offers bonuses to providers for closing care opportunities with their members. These care opportunities include well-child and *AWC* visits and *CIS—Combination 3*.
    - UHC CP QI's EPSDT RN coordinator 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 RN coordinator 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.
- An IVR outreach call campaign is being conducted by Silverlink/Welltok this year to remind members to schedule *W15, W34, AWC*, and EPSDT visits for their children.
- In Q3 2019, the clinical quality manager conducted interdepartmental "Fast & Furious" training sessions on key HEDIS pediatric measures, including *CIS—Combination 3*, *W15*, *W34*, and *AWC*.
- Materials for the Vaccine Adherence in Kids (VAKs) program are being finalized for distribution. This is a vaccination reminder program sponsored by Pfizer that targets parents of children at ages 6 months, 8 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.

- **Women's Health**
  - *Cervical Cancer Screening (CCS)*
  - *Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care* and *Postpartum Care*
    - The Postpartum Program was recently added as a UHC CP QI Disease Management program in Q3 2018 and is ongoing in 2019. All pregnant women are enrolled in the program and receive a call after delivery to remind them to attend their postpartum visit. Members are offered assistance with scheduling the appointment and transportation for the appointment if needed. A follow-up call is made to verify that the member actually attended the scheduled postpartum visit, and then a final call is made at 60 days after delivery to close out the case.
    - The Hāpai Mālama program focuses on prenatal care management, with the goal to optimize the health and well-being of all pregnant members, with particular attention given to individuals with a high-risk pregnancy and special healthcare needs. Members are given information and support on pregnancy management, including but not limited to prenatal appointments and transportation, translation services, and tobacco cessation. Members identified as having a high-risk pregnancy receive a comprehensive special health care needs face-to-face assessment.
    - To address and reduce health care disparities, in 2019 UHC CP QI began the application process for the NCQA Multicultural Healthcare (MHC) distinction. *PPC* was targeted as a measure to explore the impact of member language on receiving timely prenatal and postpartum care and whether any disparities exist.
    - UHC CP QI is participating in the 2019 Member Rewards Program (MRP), which incentivizes members with a $25 gift card to Walmart or CVS to complete *CCS* and *PPC* postpartum care. The gift card amount increased from $10 in the 2018 MRP.
    - Quality CPCs established and developed relationships with OB/GYNs through engagement in the CP-PCPi program, which offers bonuses to providers for closing care opportunities with their members. These care opportunities target preventive services and include *CCS* and timely prenatal and postpartum care.
    - In May 2019, Women's Healthcare emails went out to eligible female members ages 18 and older to encourage completion of recommended health screenings, including *CCS*.

- In Q3 2019, the clinical quality manager conducted interdepartmental "Fast & Furious" training sessions on key HEDIS measures, including *CCS* and *PPC*.
- UHCCP QI participated in the UnitedHealthcare Baby Blocks program, which is a web-based mobile tool that allows eligible pregnant members to earn rewards for attending and tracking provider visits for prenatal and postpartum care visits.
- An IVR outreach call campaign is being conducted by Silverlink/Welltok this year to remind members to schedule timely prenatal and postpartum visits. A call campaign for *CCS* will be launched later in 2019.

- **Behavioral Health (BH)**
  - *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
    - In July 2019, an educational email was sent to 83 Hawai'i BH practitioners who treated adults diagnosed with schizophrenia and/or bipolar disorder within the past 12 months. Email content included best treatment practices, information on the need for metabolic screening, HEDIS specifications, and patient and provider resources.

Planning for a Q4 2019 mail-out to both BH prescribers and PCPs is underway. The letter will inform practitioners of patients who have a schizophrenia disorder diagnosis and/or have been prescribed antipsychotic medication if they have also not had an HbA1c and/or LDL-C testing completed this year.

CAHPS—Adult Survey

2018 Recommendations

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*.

Improvement Activities Implemented

In Q2 2019, a new executive owner for our CAHPS workgroup was assigned along with the accountable owners and supporting team members from the health plan. They were assigned to each Patient Experience measure (*Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service,* and *Enrollees' Ratings*). The Coordination of Care measure was added in Q3. The workgroups were tasked to conduct a root cause analysis and develop action plans to address and improve member experience in their assigned area. The results of 2020 CAHPS will be analyzed to determine if improved member experience was achieved. Action plans are reviewed quarterly at designated quality committees.

- **Customer Service**
  - Advocate4Me (A4Me) is UHC CP QI's Customer Service delivery model that provides members with support to address their healthcare needs and successfully navigate the healthcare system. In

Q2 and Q3 2019, A4Me was reinforced during CSA staff meetings. The reinforcement training included reviewing the definition of the A4Me model, communicating expectations, and providing examples of service delivery.

- The UnitedHealthcare National Learning Solutions team provided training to CSAs in Q1 2019 on commitment setting with members and providing end-to-end customer service.
- Ownership of CSA call audits with members transitioned from the Business Process Quality Management team to Member Services management in May 2019 to improve Quality Assurance oversight. Auditors are required to conduct four audits per CSA per month, and audits place a greater emphasis on A4Me delivery.
- In Q3 2019, the CAHPS Customer Service workgroup developed and piloted a questionnaire to be used at quarterly Member Advisory Group (MAG) meetings across the State to gain member insight on UHC CP QI's strengths and weaknesses related to member experience. The questionnaire was first used at the 8/23/2019 MAG meeting on Oahu, and feedback was shared among the internal workgroups. The questionnaire will continue to be used as a discussion tool at future MAG meetings.
- At the 8/23/2019 Oahu MAG meeting, UHC CP QI staff provided members with information on the A4Me model and the services that CSAs provide. Services mentioned include assistance in finding a provider and scheduling appointments, arranging transportation for medical care, connecting to a service coordinator or other support resources, coordinating interpreter services if needed, and help with billing issues. Staff emphasized to members that CSAs are firmly committed to helping them resolve any healthcare system issues or concerns they may have. Member education on A4Me will continue in future MAG meetings.
- UHC CP QI established Self-Direct Provider Orientations to educate self-direct providers on processes and guidelines related to timesheet completion and submission deadlines, payment turnaround times, and time frames for a UHC CP QI self-direct team response. The orientations began as a pilot with one Oahu Service Coordination team in December 2018, and they have since been rolled out to all Service Coordination teams across Oahu in 2019. To date, 94 self-direct members/providers have completed the orientation. A pilot with the Hilo Service Coordination team is scheduled to begin in Q4 2019.
- CSAs started sending handwritten "Compassion Notes" to members in 2017 that contain phrases of positivity and kindness, and that practice is ongoing in 2019. In Q3 2019, a new coordinator was assigned to the project to keep track of all Compassion Notes and ensure that CSAs are creating and sending two to three notes per week to members.
- UHC CP QI continues to hold weekly meetings with our transportation vendor. Incident reports, including issues and complaints related to Customer Service, are shared at these meetings and are communicated back to the vendor staff to address areas for improvement.

- **Coordination of Care**
  - A link to a 2019 article titled, "CAHPS: Importance of Care Coordination," is posted on the UnitedHealthcare provider website at www.uhcprovider.com. The one-page resource explains what the CAHPS survey is and focuses specifically on the survey questions related to Care Coordination. It also lists ideas to help providers improve their patients' experience with Care Coordination.

- The Spring/Summer 2019 "Practice Matters" Provider Newsletter included an article that highlighted UHC CP QI's partnership with Hawai'i Health Information Exchange (HHIE). HHIE can help providers find and share clinical information that supports care coordination and continuity of care.
- UHC CP QI will publish an article in the Fall/Winter 2019 "Practice Matters" newsletter that offers providers resources to address barriers to care delivery and coordination related to language. The article will include the link for Medline Health Information in multiple languages (https://medlineplus.gov/languages/languages.html), as well as information on Language Line and Helping Hands services.
- The Service Coordination team will have a table at the Q4 2019 Provider Information Expo (PIE). Information shared with providers at the PIE will include the Service Coordination access and referral process and services that a Service Coordinator can provide, including care coordination and supporting members with getting needed care.

- **Getting Needed Care**
  - A link to a 2019 article titled, "CAHPS: Improving Getting Needed Care," is live on the UnitedHealthcare provider website at www.uhcprovider.com. The one-page resource explains what the CAHPS survey is and focuses specifically on the survey questions related to *Getting Needed Care*. It lists ideas to help providers improve their patients' experience with *Getting Needed Care*.
  - In the Spring 2019 "Health Talk" Member Newsletter, a checklist insert was included to help members prepare for PCP visits and get needed care by identifying and prioritizing items for discussion. The CAHPS workgroup is discussing the use of the checklist by service coordinators to use as a tool when helping members prepare for provider visits.
  - In the Summer 2019 "Health Talk" Member Newsletter, an article titled, "Wait No More," listed the appointment time frames within which members could expect to be seen for routine, emergency, urgent, specialty, and BH care, for both children and adults.
  - The Summer 2019 "Health Talk" Newsletter also included an article titled, "Getting the Right Care." It encourages members to see their PCPs when possible and gives general guidelines and situations when members should seek urgent or emergency care, so that members obtain the care they truly need. The number for the UnitedHealthcare NurseLine is provided for general health questions.
  - Through A4Me, CSAs help members schedule provider appointments while on the call with the member or commit to do so within the next 48 hours if immediate scheduling is not possible. UHC CP QI has started emphasizing A4Me and its services at quarterly MAG meetings in 2019, and this agenda item will be ongoing.
  - The Service Coordination team will have a table at the Q4 2019 PIE. Information shared with providers at the PIE will include the Service Coordination access and referral process and services that a service coordinator can provide, including care coordination and supporting members with getting needed care.
  - The health plan continues to explore telehealth options to expand member access to needed care for physical health.

  - We are currently working with MDLive to provide direct-to-consumer virtual visits that members access through a Web portal or mobile app. The service is for physical health visits only, and visits are at no cost to members.
  - UHC CP QI continued its contract with Direct Dermatology in 2019 to provide dermatological care to our members through its online platform.
- To facilitate member access to needed BH care, UHC CP QI is planning as well as already implementing several initiatives in 2019:
  - Utilization of the Express Access Network, which is a network of BH clinicians who have an addendum to their contract agreeing to have appointments available within five days of a member's request for an appointment. Our online directory allows for filtering by clinicians who have this availability. Currently, all participating clinicians are non-prescribers.
  - We have a network of BH clinicians who have attested to having telehealth capability with technology that has been verified and confirmed to meet our standards, in order to provide care via virtual visits.
  - UHC CP QI collaborated with Paniolo Pediatrics and Family Medicine on Hawai'i Island to provide members with access to BH clinicians through UnitedHealthcare-sponsored computers that were placed in the clinic. Implementation began in Q3 2019.
  - In 2019, UHC CP QI developed an incentive program for BH providers to receive $50 for each of our eligible members they see for follow-up within seven days after discharge, to reinforce the HEDIS *FUH* (*Follow-up after Hospitalization for Mental Illness*) measure. The target effective date is 1/1/2020.
  - At the Q4 2019 PIE, the BH team will have a booth to educate providers on its services, including the Express Access Network of BH providers, who have agreed to have appointments available within five days of request, and how members can access it.
  - The BH team also has plans to train the Service Coordination team on the Express Access Network, how to identify participating providers, and how members can access the network. Training is planned for one of the Service Coordination team's weekly Webex meetings.

Provider Survey

2018 Recommendations

Based on the survey results, UHC CP QI should focus efforts on improving the following measures which 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*

Improvement Activities Implemented

- **Compensation Satisfaction**
  - For medical providers, UHC CP QI has developed two new fee schedules that went into effect October 2018. Historically, UHCCP relied on the published Hawaii State Fee Schedule. These two new fee schedules were developed to be inclusive of all covered Medicaid benefits, as well as to be competitive among the other health plans in the market:
    - UHCCP PCP Enhanced Fee Schedule: The providers who qualify for Patient Protection and Affordable Care Act (PPACA) PCP Enhancement payments will receive full payment up front as part of the new fee schedule specific to providers who qualify.
    - UHCCP Standard Fee Schedule: Providers who do not qualify for the UHCCP PCP Enhanced Fee Schedule will be reimbursed based on the new UHCCP Standard Fee Schedule.
  - For BH providers:
    - The fee schedule was revised to be more in line with the market standards and resulted in an increase across the board for our BH providers. The effective date is 10/1/2019.
    - In 2019 UHC CP QI planned and developed an incentive program for BH providers to receive $50 for each of our eligible members they see for follow-up within seven days after discharge, to reinforce the HEDIS *FUH* (*Follow-up after Hospitalization for Mental Illness*) measure. The target effective date is 1/1/2020.
- **Timeliness of Claims Payments**
  - UHC CP QI's Standard Operating Procedures were reviewed to ensure claims are processed through the system in a timely manner and accurately.
  - UHC CP QI is meeting national standards for timeliness of claims payments. Providers are educated on claims standards through provider newsletters and town halls.
- **Prior Authorization (PA) Process**
  - UHC CP QI updated its definition of "medical necessity" in its policies and procedures (P&Ps) to include language that supports the opportunity for an enrollee receiving Long-term Services and Supports (LTSS) to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of their choice.
  - UHC CP QI has updated its P&Ps to include a description of the processes used to determine and implement LTSS authorization decisions, and how those decisions align with and ensure that the continuity of medically necessary services for LTSS members are provided based on the

member's current needs assessment and person-centered service plan and are reflective of the ongoing needs for these services to avoid disruptions in care.

- P&Ps, the Member Handbook, Care Provider Manual, and Utilization Management (UM) systems were updated to reflect time frames for making expedited authorization decisions within 72 hours instead of three days. This includes processes and updates to UHC CP's UM systems to ensure accurate time tracking of when all requests are received, decisions are rendered on time, and escalation is initiated when nearing the end of the time frame for a decision or to trigger an extension request.
- Planning was initiated in Q3 2019 for the health plan Intake team to train the Clinical Administration team on PA processes and forms requiring completion, including those related to non-clinical PA of inter-island travel. The intent is for this training to be more in-depth compared to previous general overview training, and to level set PA information among internal teams for more consistent and improved provider interactions and education.
- For BH PA processes, in 2019 the ACE Platinum Program was launched to streamline access and improve satisfaction. This program relaxes the PA review process for qualified programs and facilities that meet specific quality outcomes. This includes three inpatient BH facilities and the largest residential treatment program in the State. Providers in the community have expressed frustration in the past with different review requirements across managed care organizations, since not all health plans review the same levels of care. This ACE program is an effort to address any provider abrasion while ensuring quality service delivery.

- **Formulary**
  - The UnitedHealthcare Prescription Drug List (PDL), which is updated quarterly, is located on the provider page at the following link:

    https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/hi/pharmacy/HI-UHCCP-QUEST-Preferred-Drug-List.pdf
  - Starting in July 2019, the drug formulary, or PDL, as well as the quarterly drug updates are posted to the public site at www.UHCCP.com/hi and then from within the member portal as well at www.myuhc.com. These updates allow members to access information on formulary changes that may impact their medications.
  - The UHC CP QI Provider Advisory Committee (PAC) reviews the updated PDL and provides input during our quarterly meetings.
- **Adequate Access to Non-Formulary Drugs**
  - The Prior Notification Team that processes PAs for non-formulary drugs has transitioned from being a Community & State Entity to an OptumRx operation. This transition occurred on 4/1/19 and is aimed at providing member satisfaction as a result of operational efficiencies. The newly integrated organization will utilize talent and capabilities to build capacity for service levels and turnaround times.

- **Helpfulness of Service Coordinators**
  - Throughout 2019, Service Coordination teams received interdepartmental training on key areas related to and affecting providers. Training topics included HEDIS measures; CAHPS; provider and member incentive programs; NPS and provider satisfaction; compliance; and roles and processes within the Operations department, such as claims, appeals and grievances, member benefits, enrollment, and self-direct services.
  - The Service Coordination team will have a table at the Q4 2019 PIE. Information shared with providers at the PIE will include the Service Coordination access and referral process and services that a service coordinator can provide, including care coordination and supporting members with getting needed care.
- **Adequacy of Specialists**
  - UHC CP QI works continuously to improve the adequacy of specialists, and we are currently working to expand telehealth options to fill any specialist gaps:
    - We are currently working with MDLive to provide direct-to-consumer virtual visits that members access through a Web portal or mobile app. Visits are at no cost to members.
    - UHC CP QI continued its contract with Direct Dermatology in 2019 to provide dermatological care to our members through its online platform.
- **Adequacy of Behavioral Health Specialists**
  - UHC CP QI works continuously to improve the adequacy of specialists, and we are currently working to expand our telehealth options to fill BH specialist gaps. For example, we are currently working with Genoa Healthcare, a national partner that has providers with Hawai'i licensure, to fill gaps in BH specialists.
- **Availability of Mental Health Providers**
  - UHC CP QI uses Express Access and Virtual Visits as a way to have more BH providers available to our members:
    - Express Access Network: A network of BH clinicians who have an addendum to their contract agreeing to have appointments available within five days of a member's request for an appointment. Our online directory allows for filtering by clinicians who have this availability. Currently, all participating clinicians are non-prescribers.
    - Virtual Visits: We have a network of BH clinicians who have attested to having telehealth capability with technology that has been verified and confirmed to meet our standards.
      - The care delivery method and venue can vary—some clinicians provide direct-to-consumer care, some provide care to an originating site, and some agencies with locations on multiple islands use virtual visits through internal VCC (virtual circuit connection).
      - As an example of virtual visits through an originating site, UHC CP QI collaborated with Paniolo Pediatrics and Family Medicine on Hawai'i Island to provide members with access to BH clinicians through UnitedHealthcare-sponsored computers that were placed in the clinic. Implementation began in Q3 2019.

- **Access to Substance Abuse Treatment**
  - UHC CP QI has an adequate number of Substance Abuse Treatment Centers (SATCs) within its network. However, we understand that the demand for treatment of all levels of care for substance use disorders (SUD) continues to outpace the availability of treatment services statewide across all health plans. Faced with sharing the same finite network of treatment providers and facilities, UHC CP QI has implemented additional supplemental strategies to improve member access to care and provider and member satisfaction with services:
    - BH UM care advocates work closely with inpatient discharge planners to explore SUD treatment options prior to discharge to help facilitate entry into services.
    - BH field care advocates also collaborate more readily with treatment programs to help facilitate transportation needs of the member as well as authorization issues with our UM team.
    - In 2019, the ACE Platinum Program was launched to streamline access and improve satisfaction. This program relaxes the PA review process for qualified programs and facilities that meet specific quality outcomes. This includes three inpatient BH facilities and the largest residential treatment program in the State.
    - Future interventions will include enhancing educational materials to medical providers to highlight SATCs within our network to increase awareness of available options to our members.

'Ohana Community Care Services ('Ohana CCS)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2018 Recommendations

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.

Improvement Activities Implemented

WellCare and Ohana's HEDIS Team and IT team will ensure close review of each data source submitted in Section 5 and validate applicability to the HI Market prior to submission to ensure accurate Roadmap documentation is provided. Additionally, the QDAR HEDIS Team will run impact reports on each source in advance in order to identify measures that would be affected by each supplemental data source.

2018 HEDIS Performance Measure 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*

Improvement Activities Implemented

- Behavioral Health—*Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*
  - Pharmacy team created an educational flyer for the providers to deliver the information on the best practices for members who are taking antidepressant medication management.
  - Pharmacy team also visited BH and PCP offices to discuss the importance of medication adherence with emphasis on antidepressant medication adherence.
  - Pharmacy team and Quality department support Community Care Services team with provider trainings annually. Pharmacy team provides education on importance of medication adherence. Quality department also educates providers on all HEDIS measures with emphasis on medication adherence-related measures including antidepressant medication management and importance of member engagement to treatment.
  - In late 2018, CCS and Pharmacy Team leveraged existing partnership with 5 Minute Pharmacy, a pharmacy vendor who delivers medication to member's homes or a designated location such as Joint Outreach Center to deliver their medications, if member is homeless, in efforts to remove the identified barriers of transportation or not having an address to get their medications delivered in timely fashion.
  - Quality practice advisors have made efforts to connect with all BH providers (psychiatrists, ARNPs, and physician assistants) in the market. Then, QPAs provided an educational flyer specifically on antidepressant medication management for people taking antidepressant medication and provided guidance on best coding practices when billing.
- Utilization and Health Plan Descriptive Information—*Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*

- In CCS we hold regular IDTs (Interdisciplinary Team meetings) for the high ER utilizers. Present in those meetings are the BH manager, BH medical director, the BH case management liaison, the QI health plan, the case management agency (including the case manager and team lead), and any other providers as necessary.
- We work with the Queens Coalition for the High ER Utilizers, meeting monthly to discuss treatment plans for the individual members identified as high ER utilizers at Queens.
- If the high ER utilizer is acuity level 5 member, the case is discussed in the daily L5 huddle.
- When notified by the ER that a member is in the ER, the case manager needs to respond to the ER within 1.5 hours to prevent unnecessary hospitalization.
- Case managers follow up with their assigned CCS members within 72 hours after ER visit.
- Pharmacy and CCS team have partnered with 5 Minute Pharmacy to launch a pilot program in efforts to improve the antipsychotic medication adherence by removing identified barriers in accessing medications due to the population being prevalent in homelessness and the severity of the member's mental illness. The team determined that the pilot program will be launched for acuity level 5 members, who are identified to be more severe in their behavioral health conditions among the CCS population and needing medication such as long-acting injectable antipsychotic medication in a timely fashion to prevent acute schizophrenic episodes or visits to the ER as a way to access needed medication. If the outcome of the pilot program is identified to be successful, the team plans to expand the program to all FQHC pharmacies with CCS members assigned to them, who are needing the same or similar antipsychotic medication.

Appendix A. Methodologies for Conducting EQR Activities

Introduction

In calendar year (CY) 2019, 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 2018 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 2019, 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

2019 Compliance Monitoring Review

Objectives

The Balanced Budget Act of 1997 (BBA), as set forth in 42 CFR §438.358, requires that a state or its designee conduct a review to determine each MCO's and prepaid inpatient health plan's (PIHP's) compliance with federal managed care regulations and state standards. Oversight activities must focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries by the MCO/PIHP. To complete this requirement, HSAG—through its EQRO contract with the MQD—conducted a compliance evaluation of the health plans and the CCS program health plan. For the 2019 EQR compliance monitoring activity, which began a new three-year cycle of compliance review activities, HSAG conducted a desk audit and an on-site review of the health plans to assess the degree to which they met federal managed care and State requirements in select standard areas. The primary objective of HSAG's 2019 review was to provide meaningful information to the MQD and the QI and CCS health plans regarding contract compliance with those standards.

The following six standards were assessed for compliance:

- Standard I Coverage and Authorization of Services
- Standard II Access and Availability
- Standard III Coordination and Continuity of Care
- Standard IV Member Rights and Protections
- Standard V Member Information
- Standard VI Member Grievance System

The findings from the desk audit and the on-site review were intended to provide the MQD, the QI health plans, and the CCS program with a performance assessment and, when indicated, recommendations to be used to:

- Evaluate the quality and timeliness of, and access to, care furnished by the health plan.
- Monitor interventions that were implemented for improvement.
- Evaluate each health plan's current structure, operations, and performance on key processes.
- Initiate targeted activities to ensure compliance or enhance current performance, as needed.
- Plan and provide technical assistance in areas noted to have substandard performance.

Once each of the health plans' final compliance review report was produced, the health plan prepared and submitted a CAP for the MQD's and HSAG's review and approval. Once the CAP was approved, the health plan implemented the planned corrective actions and submitted documented evidence that the activities were completed and that the plan was now in compliance. The MQD and HSAG performed a desk review of the documentation and issued a final report of findings once the plan was determined to meet the requirement(s) and was in full compliance.

Technical Methods of Data Collection and Analysis

Prior to beginning the on-site compliance monitoring and follow-up reviews, HSAG, in collaboration with the MQD, developed a customized data collection tool to use in the review of each health plan. The content of the tool was based on applicable federal and State laws and regulations and the QI health plans' and CCS' current contracts.

HSAG conducted the compliance monitoring reviews in accordance with the CMS protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[A-1]

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: March 1, 2019.

Description of Data Obtained

To assess the health plans' compliance with federal and State requirements, HSAG obtained information from a wide range of written documents, including committee meeting agendas, minutes, and handouts; policies and procedures; reports; member and provider handbooks; monitoring reports; and provider contract templates. For the record reviews conducted at the health plans and CCS, HSAG generated audit samples based on data files that the health plan provided (i.e., listings of denials, appeals, and grievances processed within the review period). HSAG also obtained information for the compliance monitoring review through observation during the on-site review and through interaction, discussion, and interviews with key health plan staff members.

At the conclusion of each compliance review, HSAG provided the health plan and the MQD with a report of findings and any required corrective actions. The plan-specific results are summarized in Section 3 of this report.

Validation of Performance Measures—HEDIS Compliance Audits

Objectives

As set forth in 42 CFR §438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for calculation of the performance measures.
- Identify overall strengths and areas for improvement in the performance measure process.

The following table presents the state-selected performance measures and required methodology for the 2019 validation activities. Note that several measures' technical specifications were state-defined, non-HEDIS measures. Both HEDIS and non-HEDIS measures were validated using the same methodology, which is described in further detail in the following section.

Table A-1—Validated Performance Measures

Performance Measure	QI	CCS	Methodology
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services	✓		Admin
Children and Adolescents' Access to Primary Care Practitioners	✓		Admin
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	✓	✓	Admin

Performance Measure	QI	CCS	Methodology
Children's Preventive Care			
Adolescent Well-Care Visits	✓		Hybrid
Childhood Immunization Status (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^*	✓		Hybrid
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 (excluding HbA1c control < 7.0%)^*	✓		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***		✓	Admin
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	✓		Admin
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓		Admin
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	✓	✓	Admin
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	Admin
Follow-Up After Hospitalization for Mental Illness	✓	✓	Admin
Follow-Up Care for Children Prescribed ADHD Medication	✓		Admin
*Follow-Up With Assigned PCP Following Hospitalization for Mental Illness***	✓		Admin
Utilization and Health Plan Descriptive Information			
Ambulatory Care—Total	✓	✓	Admin

Performance Measure	QI	CCS	Methodology
Enrollment by Product Line—Total	✓	✓	Admin
Inpatient Utilization—General Hospital/Acute Care—Total	✓		Admin
Mental Health Utilization—Total	✓	✓	Admin
Plan All-Cause Readmissions	✓		Admin
ED Visits for Ambulatory Care-Sensitive Conditions (NYU) **	✓		Admin

** Indicates this measure is a state-specified, non-HEDIS measure.

^ KFHP QI received approval from the MQD to report six measures via the administrative methodology. These measures were *Childhood Immunization Status*; *Immunizations for Adolescents*; *Cervical Cancer Screening; 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*.

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 2019, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.* The measurement period reviewed for the health plans was CY 2018 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 health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NB	*No Benefit.* The health plan did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reported.* The health plan chose not to report the measure.
NQ	*Not Required.* The health plan was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The health plan chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (e.g., measures collected using electronic clinical data systems).

Description of Data Obtained

HSAG used a number of different methods and sources of information to conduct the validation. These included:

- Completed responses to the HEDIS Roadmap published by NCQA as Appendix 2 to *HEDIS 2019, 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.

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 Quality Compass national Medicaid HMO percentiles for HEDIS 2018 and to the previous year's rates, where applicable. Measure rates reported by the health plans, but not audited by HSAG in 2019, are not presented within this report. Additionally, certain measures do not have applicable benchmarks. For these reasons, the HEDIS 2018 rate, relative difference, and 2019 performance level values are not presented 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 national Medicaid 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

Rates shaded yellow indicate that the rate met or exceeded the MQD Quality Strategy target for HEDIS 2019. The MQD Quality Strategy targets are defined in Table A-3.

Table A-3—MQD Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target[1]
Children's Preventive Care	
Childhood Immunization Status—Combination 3	75th Percentile
Women's Health	
Breast Cancer Screening	75th Percentile
Cervical Cancer Screening	75th Percentile
Prenatal and Postpartum Care—Timeliness of Prenatal Care	75th Percentile
Care for Chronic Conditions	
Comprehensive Diabetes Care—HbA1c Testing	75th Percentile
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	50th Percentile
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	50th Percentile
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	75th Percentile
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	75th Percentile
Controlling High Blood Pressure[2]	75th Percentile
Medication Management for People With Asthma—Medication Compliance 50%—Total	75th Percentile
Medication Management for People With Asthma—Medication Compliance 75%—Total	75th Percentile

Measure	MQD Quality Strategy Target[1]
Behavioral Health	
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	75th Percentile
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up	75th Percentile
Utilization and Health Plan Descriptive Information	
Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total	90th Percentile

[1] The MQD Quality Strategy targets are based on NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2018.
[2] Due to changes in the technical specifications for this measure in HEDIS 2019, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, comparisons to benchmarks (i.e., the MQD Quality Strategy target) were not performed for this measure.

For the following measures, a lower rate indicates better performance: *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits, Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*, and *Plan All-Cause Readmissions*.

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.[A-2] Additionally, HSAG's PIP process facilitates frequent communication with the health plans.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Mar 26, 2019.

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 2019, the health plans completed PIP topics that were initiated in 2017 and subsequently started new PIP topics selected by the MQD, submitting Modules 1 and 2 for validation.

The PIP topics are included in Table A-4 and Table A-5.

Table A-4—Completed PIP Topics in 2019 (Module 4 and Module 5)

Health Plan	PIP Topic
AlohaCare QI	• *Getting Needed Care* • *Improving Timeliness of Prenatal and Postpartum Care*
HMSA QI	• *Getting Needed Care* • *Improving Timeliness of Prenatal and Postpartum Care*
KFHP QI	• *Getting Needed Care* • *Medication Management for People with Asthma Ages 5–64*
'Ohana QI	• *Getting Needed Care* • *Improving Timeliness of Prenatal and Postpartum Care*
UHC CP QI	• *Getting Needed Care* • *Improving Timeliness of Prenatal and Postpartum Care in Hawai'i County*
'Ohana CCS	• *Follow-Up After Hospitalization for Mental Illness* • *Behavioral Health Assessment*

Table A-5—New PIP Topics in 2019 (Module 1 and Module 2)

Health Plan	PIP Topic
AlohaCare QI	• *Adolescent Well-Care Visits* • *Follow-Up After Hospitalization for Mental Illness*
HMSA QI	• *Adolescent Well-Care Visits* • *Follow-Up After Hospitalization for Mental Illness*
KFHP QI	• *Adolescent Well-Care Visits* • *Follow-Up After Hospitalization for Mental Illness*
ʻOhana QI	• *Adolescent Well-Care Visits* • *Follow-Up After Hospitalization for Mental Illness*
UHC CP QI	• *Adolescent Well-Care Visits* • *Follow-Up After Hospitalization for Mental Illness*
ʻOhana CCS	• *Follow-Up After Hospitalization for Mental Illness* • *Follow-Up After Emergency Department Visit for Mental Illness*

2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Child Survey

Objectives

The primary objective of the Child Medicaid CAHPS survey was to effectively and efficiently obtain information on Hawaii child Medicaid members' experiences with their health plan and healthcare. Parents/caretakers completed the surveys on behalf of the child members. Results were provided to the MQD at both the plan-specific and statewide aggregate report levels.

The primary objective of the CHIP CAHPS survey was to obtain experience of care information from the Hawaii CHIP population to provide to the MQD and to meet the State's obligation for CHIP CAHPS measure reporting to CMS. Results were provided to the MQD in a statewide aggregate report.

Technical Methods of Data Collection and Analysis

Data collection for the Child CAHPS survey and the CHIP CAHPS survey was accomplished through administration of the CAHPS 5.0H Child Medicaid Health Plan Survey instrument (without the children with chronic conditions [CCC] measurement set) to child members enrolled in the QI health plans and CHIP. Child members eligible for surveying were 17 years of age or younger as of December 31, 2018. All parents/caretakers of sampled members completed the surveys from February to May 2019 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese. The CAHPS 5.0H Health Plan Survey process allows for two methods by which parents/caretakers of

sampled members could 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 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 non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled members who had not mailed in a completed survey or requested the option to complete the survey in one of the alternate languages. It is important to note that the CAHPS 5.0H Health Plan Survey is made available by NCQA in English and Spanish only. Therefore, prior to the start of the CAHPS Survey process, and in following NCQA HEDIS Specifications for Survey Measures, HSAG submitted a request for a survey protocol enhancement and received NCQA's approval to allow the parents/caretakers of sampled child members the option to complete the CAHPS survey in the designated alternate languages.[A-3]

The Child CAHPS survey included a set of standardized items (48 questions) that assessed parents'/caretakers' perspectives on their child's care. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed to select the child Medicaid 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 Child Medicaid Health Plan Survey results was conducted following 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 experience. 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 members' overall experience with the health plan, healthcare, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* or *Getting Care Quickly*). The individual item measures are individual questions that consider a specific area of care (i.e., *Coordination of Care* and *Health Promotion and Education*).

For each of the four global ratings, the percentage of respondents who chose the top experience rating (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the five composite measures and two individual item measures, the percentage of respondents who chose a positive response was

[A-3] National Committee for Quality Assurance. *HEDIS® 2019, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2018.

calculated. Response choices for CAHPS composite and individual item measure questions 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 and individual item measures was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses for each CAHPS measure is referred to as a "top-box score."

For each CAHPS measure, the resulting child Medicaid and CHIP top-box scores were compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data.[A-4,A-5,A-6] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, with one being the lowest possible rating and five being the highest possible rating, using the following percentile distributions:

★★★★★	indicates a score at or above the 90th percentile
★★★★	indicates a score at or between the 75th and 89th percentiles
★★★	indicates a score at or between the 50th and 74th percentiles
★★	indicates a score at or between the 25th and 49th percentiles
★	indicates a score below the 25th percentile

Additionally, HSAG performed a trend analysis of the child Medicaid and CHIP results. For CHIP, the 2019 CAHPS scores were compared to their corresponding 2018 CAHPS scores to determine whether there were statistically significant differences. For child Medicaid, the 2019 CAHPS scores were compared to their corresponding 2017 CAHPS scores to determine whether there were statistically significant differences.[A-7] Lastly, the 2019 CAHPS scores of the child Medicaid QI health plans, the QI statewide aggregate, and CHIP were compared to the 2018 NCQA child Medicaid national averages.[A-8] These comparisons were performed for the four global ratings, five composite measures, and two individual item measures.

Description of Data Obtained

The CAHPS survey asks parents/caretakers to report on and to evaluate their experiences with their child's 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 2019 and were designed to achieve the highest possible response rate. The CAHPS survey response rate is the

[A-4] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018*. Washington, DC: NCQA, September 2018.
[A-5] Quality Compass 2019 data were not available at the time this report was prepared; therefore, 2018 data were used for comparison.
[A-6] NCQA's benchmarks for the child Medicaid population were used to derive the overall member experience ratings; therefore, caution should be exercised when interpreting the CHIP results.
[A-7] HSAG did not survey the child Medicaid population in 2018.
[A-8] NCQA national averages for the child Medicaid population are used for comparative purposes, since NCQA does not publish separate benchmarking data for the CHIP population.

total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the designated five questions were completed.[A-9] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria) or had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the Child CAHPS survey, HSAG provided the MQD with plan-specific reports of findings and a statewide aggregate report. The MQD also received a statewide aggregate report of the CHIP survey results.

The QI health plan-specific results of the Child CAHPS survey are summarized in Section 3 of this report, and the CHIP results of the Child CAHPS survey are summarized in Section 1 of this report. A statewide comparison of each child Medicaid QI health plan and the QI Program aggregate results, as well as CHIP population results, are provided in Section 4.

[A-9] A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed: questions 3, 15, 27, 31, and 36.