State of Hawaii

Department of Human Services

Med-QUEST Division

2020 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

February 2021

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Overview

The 2020 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 (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 (SMI).

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 (MCOs) 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') October 2019 revised external quality review (EQR) protocols update 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] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: April 21, 2020.

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 virtual compliance reviews in July 2020. The health plans submitted documentation that was in effect March 1, 2019, through February 28, 2020. HSAG provided detailed, final audit reports to the health plans and the MQD in September 2020.
- *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 2020, the health plans continued with the PIPs that were initiated in 2019. The health plans passed Modules 1 through 3 and had initiated testing of the interventions. The PIP timeline specified that health plans should test interventions until January 31, 2021, and thereafter complete the final analysis in Modules 4 and 5. HSAG will validate the PIP outcome results in April 2021.
- *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 2020 through July 2020. The final PM validation results generally reflect the

[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.

measurement period of January 1, 2019, through December 31, 2019. HSAG provided final audit reports to the health plans and the MQD in July 2020.

- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys*.[1-5] The MQD conducted CAHPS surveys of the adult QI health plans and Children's Health Insurance Program (CHIP) populations to learn more about members' experiences with care. The standardized survey instrument administered to adult Medicaid members of the QI health plans and parents/caretakers of child members enrolled in CHIP was the CAHPS 5.0H Adult Medicaid Health Plan Survey and CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with chronic conditions [CCC] measurement set), respectively. All sampled members completed the surveys from February to May 2020. HSAG aggregated and produced final reports in September 2020.
- *Encounter data validation.* HSAG and the MQD initiated an encounter data validation study in early 2020. The study focuses on three evaluation activities designed to evaluate the completeness and accuracy of the MQD's encounter data relative to the health plan-supplied rate data in support of its rate setting activities. The three activities included are (1) targeted encounter data information systems (IS) assessment; (2) gap analysis and best practice recommendations for data quality assessment; and (3) administrative profile—assessment of encounter data accuracy, completeness, and timeliness. HSAG developed a customized questionnaire to gather information regarding each organization's IS and data processing procedures. HSAG also developed a data submission requirements document to request data to be extracted from the MQD's data system in order to conduct the administrative profile analysis. HSAG received the questionnaire responses from the MCOs and the MQD as well as data that were requested from the MQD. At the time of this report, the study was ongoing; therefore, results of the 2020 study will be presented in the 2021 HI EQR Technical Report.

COVID-19 Implications

As a result of the declaration of a national public health emergency in March 2020 related to the coronavirus disease 2019 (COVID-19) outbreak in the United States, changes were made to the following EQR activities in 2020:

Compliance Monitoring Reviews

HSAG coordinated and conducted remote, web-based virtual site visits in lieu of on-site visits.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG coordinated and conducted remote, web-based virtual site visits in lieu of on-site visits.

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

Reporting of Performance Measure Rates

Under guidance of NCQA and allowances by the MQD, health plans were given an option to submit audited rates for measures with a hybrid option if the HEDIS 2019 (measurement year [MY] 2018) rate was better than the HEDIS 2020 rate. For any measure reported using HEDIS 2019 (MY 2018) rates, the health plans were still required to submit a reporting year (RY) 2020 (MY 2019), non-audited rate to the MQD. The measures rotated during HEDIS 2020 were:

- HMSA QI—*Prenatal and Postpartum Care*, *Well-Child Visits in the First 15 Months of Life*
- 'Ohana QI—*Adolescent Well-Care Visits*, *Comprehensive Diabetes Care* (excluding *HbA1c Control <7.0%*)
- UHC CP QI—*Childhood Immunization Status—Combination 3*; *Immunizations for Adolescents*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Provider Survey

In anticipation of a low response rate from healthcare providers during the pandemic, the MQD requested that administration of the QI Provider Survey be postponed until 2021.

Overall Summary of Health Plan Performance

Compliance Monitoring Review

Calendar year (CY) 2020 began the second year of a three-year cycle of compliance reviews for the QI health plans and the CCS program.

For the 2020 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 eight areas of review, or standards. Both a pre-on-site desk review and credentialing file review and an on-site review with interview sessions and system and process demonstrations were conducted.

The second compliance review activity in 2020 involved HSAG's and the MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to findings from the 2020 compliance review, which are expected to be fully addressed by March 2021.

Findings, Conclusions, and Recommendations

Table 1-1 summarizes the results from the 2020 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 eight 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.

Table 1-1—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
Provider Selection	90%	100%	90%	100%	100%	100%	**97%**
Subcontracts and Delegation	95%	100%	70%	95%	100%	95%	**93%**
Credentialing	100%	99%	99%	100%	100%	100%	**99%**
Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	**100%**
Health Information Systems	100%	100%	100%	100%	100%	100%	**100%**
Practice Guidelines	100%	100%	100%	100%	100%	100%	**100%**
Program Integrity	100%	95%	91%	100%	91%	100%	**96%**
Enrollment and Disenrollment	100%	100%	100%	100%	100%	100%	**100%**
Totals	**99%**	**99%**	**95%**	**99%**	**99%**	**99%**	**98%**

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

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. Four standards were found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—*Quality Assessment and Performance Improvement*, *Health Information Systems*, *Practice Guidelines*, and *Enrollment and Disenrollment*. The *Subcontracts and Delegation*, *Program Integrity,* and *Provider Selection* standards were identified as having the greatest opportunity for improvement with statewide compliance scores of 93 percent, 96 percent, and 97 percent respectively. However, while the *Subcontracts and Delegation* standard exhibited the lowest overall performance (i.e., 93 percent), this statewide compliance score was largely driven by KFHP QI's low score (i.e., 70 percent). Conversely, lower performance on the *Program Integrity* standard was consistent across the health plans, with three health plans scoring below the statewide average.

Individual health plan performance revealed the following:

- AlohaCare QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards except *Provider Selection*.
  - AlohaCare QI had a total compliance score of 99 percent with six of the standards scoring 100 percent: *Credentialing*, *Quality Assessment and Performance Improvement*, *Health Information Systems*, *Practice Guidelines*, *Program Integrity*, and *Enrollment and Disenrollment*. One

element in the *Provider Selection* standard and one element in the *Subcontracts and Delegation* standard were found to be noncompliant.

  - AlohaCare QI was required to develop a corrective action plan (CAP) to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.

- HMSA QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards except *Program Integrity*.
  - HMSA QI had a total compliance score of 99 percent with six of the standards scoring 100 percent: *Provider Selection*, *Subcontracts and Delegation*, *Quality Assessment and Performance Improvement*, *Health Information Systems*, *Practice Guidelines*, and *Enrollment and Disenrollment*. One element in the *Credentialing* standard and one element in the *Program Integrity* standard were found to be noncompliant.
  - HMSA QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor HMSA QI's CAP activities until the health plan is found to be in full compliance.
- KFHP QI's performance across all standards was moderate, meeting or exceeding the statewide compliance score for five of the eight standards.
  - KFHP QI had the lowest performance with a total compliance score of 95 percent and four of the standards scoring 100 percent: *Quality Assessment and Performance Improvement*, *Health Information Systems*, *Practice Guidelines*, and *Enrollment and Disenrollment*. Ten elements across the *Provider Selection*, *Subcontracts and Delegation*, *Credentialing*, and *Program Integrity* standards were noncompliant.
  - KFHP QI's total compliance score was driven by low compliance noted in the *Subcontracts and Delegation* (70 percent) and *Provider Selection* (90 percent) standards.
  - KFHP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor KFHP QI's CAP activities until the health plan is found to be in full compliance.
- 'Ohana QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - 'Ohana QI had a total compliance score of 99 percent with seven of the standards scoring 100 percent: *Provider Selection*, *Credentialing*, *Quality Assessment and Performance Improvement*, *Health Information Systems*, *Practice Guidelines*, *Program Integrity*, and *Enrollment and Disenrollment*. One element in the *Subcontracts and Delegation* standard was found to be noncompliant.
  - 'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana QI's CAP activities until the health plan is found to be in full compliance.
- UHC CP QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards except *Program Integrity*.
  - UHC CP QI had a total compliance score of 99 percent with seven of the standards scoring 100 percent: *Provider Selection*, *Subcontracts and Delegation*, *Credentialing*, *Quality Assessment*

and Performance Improvement, *Health Information Systems*, *Practice Guidelines*, and *Enrollment and Disenrollment*. Two elements in the *Program Integrity* standard were found to be noncompliant.
  - UHC CP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor UHC CP QI's CAP activities until the health plan is found to be in full compliance.
- 'Ohana CCS' performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - 'Ohana CCS had a total compliance score of 99 percent with seven of the standards scoring 100 percent: *Provider Selection*, *Credentialing*, *Quality Assessment and Performance Improvement*, *Health Information Systems*, *Practice Guidelines*, *Program Integrity*, and *Enrollment and Disenrollment*. One element in the *Subcontracts and Delegation* standard was found to be noncompliant.
  - 'Ohana CCS was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

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

The QI health plans' and CCS' CAP implementation resulting from HSAG's 2019 compliance review was also monitored by HSAG and the MQD in 2020. All health plans successfully closed out their CAPs by May 2020, with most interventions focusing on policies, procedures, forms, and member information. Deficiencies from the 2020 compliance reviews are currently under CAPs and continue to be monitored by HSAG and the MQD.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the *HEDIS 2020 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.*[1-6] The audit procedures were also consistent with the CMS protocol for performance measure validation: *CMS External Quality Review (EQR) Protocols*.[1-7] The health plans that contracted with the MQD during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit incorporated a detailed assessment of the health plans' 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

[1-6] National Committee for Quality Assurance. *HEDIS 2020 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.* Washington, DC: NCQA; 2019.
[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols*, *October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Nov 5, 2020.

measurement period was CY 2019 (January 1, 2019, through December 31, 2019), and the audit activities were conducted concurrently with HEDIS 2020 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 17 measures, yielding a total of 52 measure indicators, for the QI population. 'Ohana CCS was required to report on 8 measures, yielding a total of 20 measure indicators, for the CCS program. The measures were organized into the following five categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services.

- Access and Risk-Utilization
- Children's Preventive Health
- Women's Health
- Care for Chronic Conditions
- Behavioral Health

Findings, Conclusions, and Recommendations

NCQA HEDIS Compliance Audit

HSAG evaluated each QI health plan's compliance with NCQA IS standards during the 2020 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. Overall, the health plans followed the NCQA HEDIS 2020 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 2020 (CY 2019) 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 2019 (referred to throughout this report as percentiles).[1-8] 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.[1-9]

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*

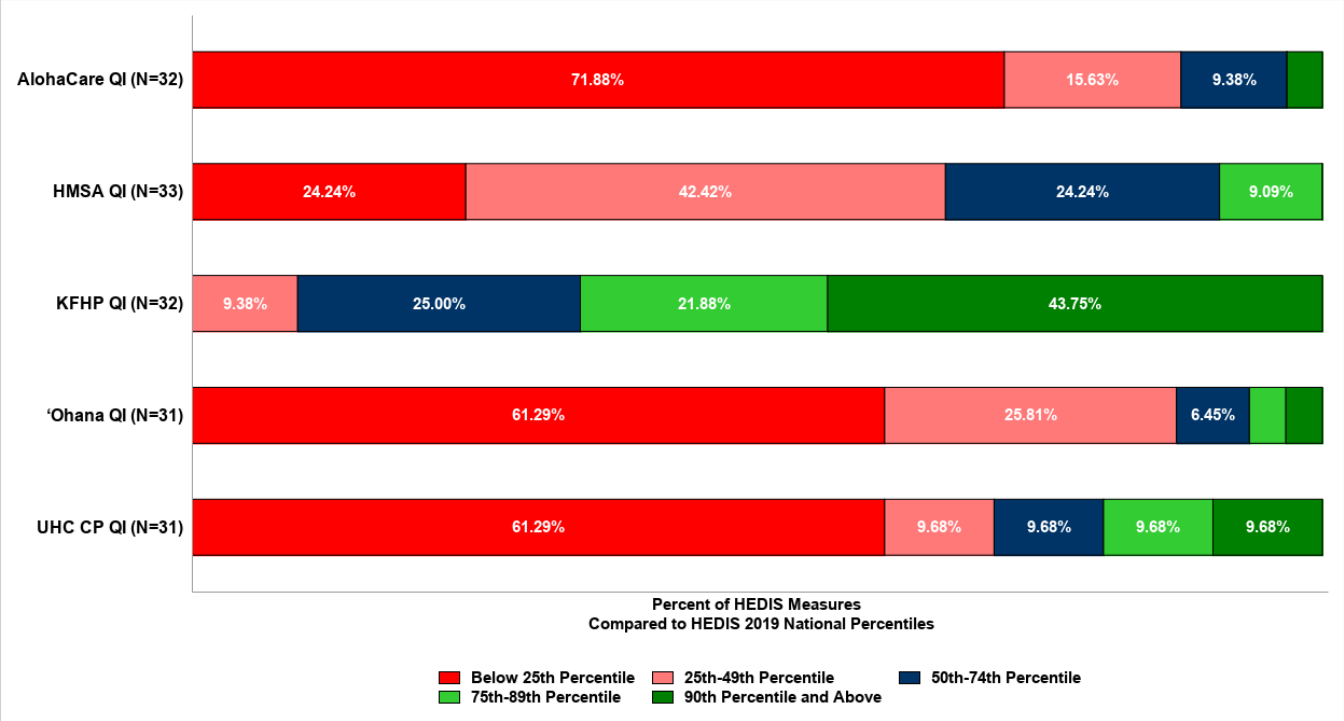
[1-8] Quality Compass® is a registered trademark of the NCQA.
[1-9] For example, because the value associated with the 10th percentile reflects better performance, HSAG reversed the percentile to the measure's 90th percentile. Similarly, the value associated with the 25th percentile was reversed to the 75th percentile.

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 2020 performance compared to benchmarks, where applicable. HSAG analyzed results from 17 performance measures for HEDIS 2020 (a total of 52 indicator rates), of which 33 indicators were comparable to benchmarks.[1-10] Of note, only one of the health plans had reportable rates for all 33 indicators; the other health plans had at least one measure indicator receive an audit designation of *NA* (i.e., *Small Denominator*).

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 2020 with 29 of 32 (90.6 percent) measure rates ranking at or above the 50th percentile, including 14 of the rates (43.8 percent) exceeding the 90th percentile. HMSA QI was the second-highest performing health plan with 11 of 33 (33.3 percent) measure rates ranking at or above the 50th percentile, including six of the rates (18.2 percent) ranking above the 75th percentile. For UHC CP QI, nine of 31 (29.0 percent) measure

[1-10] 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.

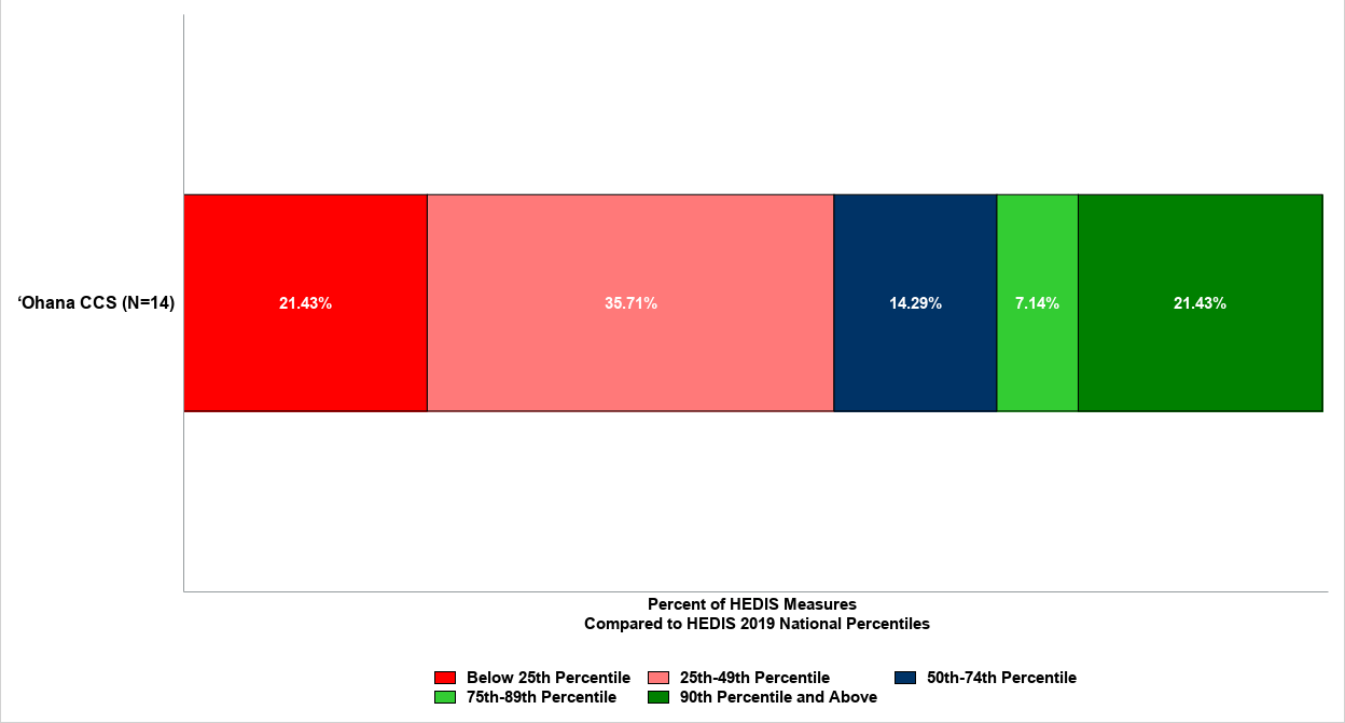
rates ranked at or above the 50th percentile, with 6 of the rates (19.4 percent) ranking at or above the 75th percentile.

Conversely, AlohaCare QI and ‘Ohana QI fell below the 50th percentile for 28 of 32 (87.5 percent) and 27 of 31 (87.1 percent) measure rates, respectively, indicating opportunities for improvement. Further, 23 (71.9 percent) of AlohaCare QI’s measure rates and 19 (61.3 percent) of ‘Ohana 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, 10 of 12 measures with MQD Quality Strategy targets were comparable to benchmarks for HEDIS 2020. KFHP QI demonstrated positive performance, meeting all 10 (100 percent) targets. Conversely, the remaining four QI health plans demonstrated opportunities to improve care overall by meeting fewer than four of the targets: AlohaCare QI (two targets met), HMSA QI (two targets met), ‘Ohana QI (two targets met), and UHC CP QI (three targets met).

Figure 1-2 displays the ‘Ohana CCS’ HEDIS 2020 (CY 2019) performance on those measure indicators that could be compared to benchmarks.

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



‘Ohana CCS demonstrated overall strength, with six of 14 (42.9 percent) measure rates ranking at or above the 50th percentile, including four of the rates (28.6 percent) ranking above the 75th percentile. Conversely, three of 14 (21.4 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 2020.

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.

In 2020, HSAG validated two PIPs for each of the five QI health plans—AlohaCare QI, HMSA QI, KFHP QI, ‘Ohana QI, and UHC CP QI; and for one CCS plan—‘Ohana CCS. The PIP topics for all the QI health plans were *Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness*. The PIP topics for ‘Ohana CCS were *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness*. The PIPs addressed CMS’ requirements related to quality outcomes—specifically, access to, and timeliness of care and services.

Findings, Conclusions, and Recommendations

In 2020, HSAG validated two PIPs for each of the QI and CCS health plans, for a total of 12 PIPs. All health plans successfully achieved all validation criteria in Modules 1 through 3 for both PIPs and progressed to testing interventions. The health plans submitted Module 4 (intervention testing using Plan-Do-Study-Act [PDSA]) for each intervention selected for testing. HSAG provided recommendations for the pre-validation review of the Module 4 submissions. Additionally, HSAG completed Module 4 check-ins with the health plans to report on the progress of each PIP. HSAG reviewed the updates and provided recommendations to the health plans and the MQD. In 2020, the health plans had not yet progressed to reporting the PIP’s SMART (Specific, Measurable, Achievable, Realistic, and Timely) Aim measure outcomes. Each health plan will submit its final Module 4 and Module 5 (PIP conclusions) approximately 10 weeks after the SMART Aim end date of January 31, 2021. The Module 4 and Module 5 validation results will be reported in the 2021 HI EQR Technical Report.

Following validation of the health plans’ 2020 PIPs, HSAG concluded:

- The health plans successfully completed Modules 1 through 3 and progressed to Module 4 for each PIP topic. The health plans designed a methodologically sound project for both PIPs and were successful in building quality improvement teams and establishing collaborative partnerships. The health plans also successfully completed Module 3 and identified opportunities for improvement and potential interventions to address the identified flaws or gaps.

- The health plans submitted Module 4 intervention testing progress updates for each PIP topic upon request.
- In the Module 4 progress updates, most of the health plans documented COVID-19 pandemic-related challenges toward intervention testing.
- The health plans requested PIP technical assistance from HSAG, as needed.

HSAG recommends the following:

- The health plans should ensure that interventions tested for the PIP reach enough members to impact the SMART Aim.
- The health plans should address all Module 4 pre-validation review and progress update feedback in the final submission of Module 4.
- The health plans should use approved measure definitions and data collection methods for the duration of the PIP so that the final measurement results allow for a valid comparison to the goal and a valid assessment of demonstrated improvement.
- The health plans should document COVID-19 pandemic-related challenges in Module 4 and Module 5 submissions, and clearly indicate if any modifications were made to the interventions based on those challenges.
- The health plans should accurately and clearly report intervention testing results and SMART Aim measure results, communicating any evidence of improvement and demonstrating the link between intervention testing and demonstrated improvement. The health plans should report numerators, denominators, and percentage results at least monthly for the SMART Aim measure and intervention effectiveness measure(s).
- The health plans should use the PIP Reference Guide and contact HSAG as often as needed for PIP technical assistance.

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

The CAHPS health plan surveys are standardized survey instruments which measure patients' experience with their healthcare. For 2020, HSAG administered the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members of the QI health plans and the CAHPS 5.0 Child Medicaid Health Plan Survey to a statewide sample of CHIP members who met age and enrollment criteria. All members of sampled adult Medicaid and parents/caretakers of CHIP members completed the surveys from February to May 2020 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.[1-11] Standard survey administration protocols were followed in

[1-11] Please note that administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.0H Adult Medicaid Health Plan Survey is made available by NCQA in English, Spanish, and Chinese only. The standard Chinese translation for the adult Medicaid CAHPS survey can only be used for the mail survey protocol. 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.

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 nine 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*), four composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), and one individual item measure (*Coordination of Care*). The scoring of the global ratings, composite measures, and individual item measure 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.

Findings, Conclusions, and Recommendations

Table 1-2 presents the 2020 percentage of top-box responses for the QI Program aggregate compared to the 2019 NCQA adult Medicaid national averages and the corresponding 2018 top-box scores.[1-12,1-13] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the QI Program aggregate's top-box scores compared to NCQA's 2019 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-14]

Table 1-2—QI Program Adult CAHPS Results

Measure	2018 Scores	2020 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	63.1%	64.3%	★★★
Rating of All Health Care	56.5%	57.7%	★★★
Rating of Personal Doctor	66.7%	69.4%	★★★
Rating of Specialist Seen Most Often	68.2%	69.2%	★★★
Composite Measures			
Getting Needed Care	83.4%	80.3% ▼	★
Getting Care Quickly	81.8%	79.0% ▼	★
How Well Doctors Communicate	93.4%	94.0%	★★★★
Customer Service	89.3%	87.3%	★★
Individual Item Measure			
Coordination of Care	84.0%	88.2% ▲	★★★★

[1-12] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: Aloha Care QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI.

[1-13] The child population was last surveyed in 2019; therefore, the 2020 adult CAHPS scores are compared to the corresponding 2018 scores.

[1-14] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019.* Washington, DC: NCQA, September 2019.

Measure	2018 Scores	2020 Scores	Star Ratings
Cells highlighted in yellow represent scores that are at or above the 2019 NCQA adult Medicaid national averages. Cells highlighted in red represent scores that are below the 2019 NCQA adult Medicaid national averages. ▲ Indicates the 2020 score is statistically significantly higher than the 2018 score. ▼ Indicates the 2020 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			

Comparison of the QI Program's 2020 scores to the 2019 NCQA adult Medicaid national averages revealed the following summary results:

- The QI Program's scores were at or above the national average on six measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Coordination of Care*.
- The QI Program's scores were below the national average on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Comparison of the QI Program's 2020 scores to the corresponding 2018 scores revealed the following summary results:

- The QI Program's 2020 score was statistically significantly higher than the 2018 score on one measure, *Coordination of Care*.
- The QI Program's 2020 scores were statistically significantly lower than the 2018 scores on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Comparison of the QI Program's 2020 scores to the 2019 NCQA adult Medicaid Quality Compass data revealed the following:

- The QI Program did not score at or above the 90th percentile on any of the measures.
- The QI Program scored below the 25th percentile on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Table 1-3 presents the 2020 percentage of top-box responses for the Hawaii CHIP population compared to the 2019 NCQA child Medicaid national averages and the corresponding 2019 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 2019 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-15]

[1-15] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

Table 1-3—CHIP CAHPS Results

	2019 Scores	2020 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	71.4%	72.6%	★★★
Rating of All Health Care	66.4%	66.6%	★
Rating of Personal Doctor	77.1%	76.7%	★★
Rating of Specialist Seen Most Often	67.9%+	69.5%+	★
Composite Measures			
Getting Needed Care	76.0%	80.4%	★
Getting Care Quickly	85.3%	87.8%	★★
How Well Doctors Communicate	95.8%	95.9%	★★★★
Customer Service	84.7%+	85.1%	★
Individual Item Measure			
Coordination of Care	91.2%	82.3% ▼	★★

Cells highlighted in yellow represent scores that are at or above the 2019 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2019 NCQA child Medicaid national averages.
▲ Indicates the 2020 score is statistically significantly higher than the 2019 score.
▼ Indicates the 2020 score is statistically significantly lower than the 2019 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 2020 scores compared to the 2019 NCQA child Medicaid national averages revealed the following summary results:

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

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

- The CHIP population's 2020 score was statistically significantly lower than the 2019 score on one measure, *Coordination of Care*.

Comparison of the CHIP population's scores to the NCQA's 2019 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The CHIP population did not score at or above the 90th percentile on any of the measures.
- The CHIP population scored below the 25th percentile on four measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service.*

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

Encounter Data Validation

At the time of this report, the study was ongoing, and the analysis of the data obtained from the 2020 encounter data validation activities will be completed in early 2021. As such, findings, conclusions, and recommendations will be included in the 2021 HI EQR Technical Report.

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 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.

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

[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.

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 Measure Validation

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 Project (PIP) Validation

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).

Encounter Data Validation

Validation of encounter data reported by an MCO, PIHP, PAHP, or PCCM entity is one of the optional external quality review activities described at 42 CFR§438.358(c)(1).

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, 2020, through December 31, 2020, 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, two 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
    - Encounter Data Validation
    - 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 375,000[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 November 2020, as cited in *Hawaii Medicaid Enrollment for the Year 2020,* available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/enrollment-reports/2020_09_MQD_Enrollment_Report.pdf Accessed on: November 30, 2020.

[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: November 30, 2020.

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 nearly 70,000 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 175,000 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 35,000 enrolled Medicaid members on the islands of Maui and Oahu.

'Ohana QI

'Ohana QI is offered by Centene Corporation. Formerly a subsidiary of WellCare Health Plans, Inc., Centene Corporation completed its acquisition of WellCare in January 2020 and now provides healthcare in all 50 states. Centene Corporation offers government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. '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 55,000 Medicaid members in Hawaii, UHC CP also administers Medicare dual-eligible special needs plans and commercial health plans. UHC CP initially

began operating as a QExA health plan in Hawaii on February 1, 2009, and then also as a QUEST plan on July 1, 2012.

'Ohana CCS

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

The State's Quality Strategy[2-4]

In keeping with the requirements specified by CFR §438.340, the QUEST Integration Quality Strategy was filed with CMS in 2014 and approved in July 2016. The *purpose* of the strategy is:

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

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

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

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

[2-4] QUEST Integration Quality Strategy. State of Hawaii, Department of Human Services, Med-QUEST Division. Available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/quality-strategy/7-7-2016-HI-MQD-Quality-Strategy-Approved.pdf. Accessed on 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.

In 2020, the MQD revised its Quality Strategy and released the draft for public review and comment in August 2020. The MQD submitted the Quality Strategy to CMS in October 2020 and is awaiting final approval.

3. Assessment of Health Plan Performance

Introduction

This section of the report describes the results of HSAG's 2020 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,* October 2019.
[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 2020 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 2020 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	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	4	1	0	1	90%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	39	32	32	0	0	7	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%

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

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**93**	**91**	**2**	**0**	**8**	**99%**

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

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

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

Strengths

Overall, AlohaCare QI performed above average on the compliance review, scoring 100 percent on six of the eight standards reviewed in 2020.

Credentialing:

AlohaCare QI demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing individual licensed practitioners that effectively evaluated practitioners and complied with the NCQA credentialing standards and guidelines. Practitioner credentialing and recredentialing applications contained all required information and confirmed that AlohaCare QI maintained comprehensive and well-organized credentialing and recredentialing files.

Quality Assessment and Performance Improvement:

AlohaCare QI's quality assessment and performance improvement (QAPI) program was supported by a comprehensive program description, work plan, and evaluation of the prior year's quality improvement program achievements. The QAPI program provided the framework to systematically measure and analyze performance and impart essential information that aided management in decision making to improve organizational functions, structures, and processes to improve QI member outcomes. The annual QAPI work plan described improvement activities that included major objectives, planned activities, regulatory requirement, reporting methods, identification of responsible individuals or groups, and time frames for completion. The work plan also functioned as the basis for the health plan's annual evaluation of its QAPI program.

Health Information Systems:

AlohaCare QI demonstrated its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. AlohaCare QI had processes in place to verify the accuracy and completeness of its claims and encounter data by conducting claims audits and running the data through various system edits within its

claims and encounter data reporting systems. The health plan also had data security measures, policies, and plans related to disaster planning and recovery and business continuity.

Practice Guidelines:

AlohaCare QI implemented processes for the adoption, review, and dissemination of clinical practice guidelines (CPGs). AlohaCare QI had a variety of CPGs for medical conditions, behavioral health, and preventive care that included diabetes, chronic obstructive pulmonary disease (COPD), diagnosis and treatment management of attention deficit/hyperactivity disorder (ADHD) in school aged children, and adult preventive health. The health plan had processes for regular dissemination of CPG information to providers, and members were informed of how to access CPGs through information provided in the annual member information bulletin.

Program Integrity:

AlohaCare QI had a compliance plan and several policies and procedures that guided the health plan's compliance program. AlohaCare QI provided initial onboarding and annual training to all employees about various compliance topics including identification and reporting of suspected fraud, waste, and/or abuse (FWA), employee code of conduct, whistleblower and non-retaliation laws, and privacy and security. AlohaCare QI utilized Compliance 360, an application for tracking and reporting compliance activities and FWA investigations. AlohaCare QI implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. AlohaCare QI also had processes in place to report overpayments to the State.

Enrollment and Disenrollment:

AlohaCare QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. As all member enrollment and disenrollment decisions were made by the State, AlohaCare QI customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. AlohaCare QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

AlohaCare QI was found to be 95 percent compliant with the Subcontracts and Delegation standard, with one element scoring a *Partially Met.* The health plan had several executed subcontracts for various health plan administrative functions. AlohaCare QI had policies and procedures for monitoring, oversight, and evaluation of its delegated entities. A review of the subcontracts revealed that the medical record retention requirements were inconsistent with the State's retention policy of 10 years. The corrective action required by AlohaCare QI was to amend the subcontracts to include a provision that the subcontractor must retain medical records in compliance with the State's health plan contract (10 years).

AlohaCare QI was found to be 90 percent compliant with the Provider Selection standard, with one element scoring a *Partially Met*. Overall, AlohaCare QI had a comprehensive process for the selection of its network providers to sufficiently meet the needs of its QI members. However, the health plan's policies were missing key provisions and timelines for notifying providers and the State when a provider or group is declined participation in the network. The corrective action required by AlohaCare QI was to ensure that mechanisms are in place to provide written notice of the reason for the health plan's decision to decline an individual or groups of providers in its network to affected providers at least 30 days prior to the effective date and notify DHS at least 45 days prior to the effective date if the individuals or providers represent 5 percent or more of the total providers in that specialty, or if it is a hospital.

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 14 standard supplemental and one non-standard data sources for its performance measure reporting. No concerns were identified, and these sources were approved for HEDIS 2020 measure reporting. All convenience samples passed HSAG's review.

The auditors did not have any recommendations for AlohaCare QI.

All QI measures that AlohaCare QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted. For AlohaCare QI reporting, the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicator 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—*Prenatal and Postpartum Care—Postpartum Care*
- Group B: Anticipatory Guidance & Counseling—*Well-Child Visits in the First 15 Months of Life—Five Well-Child Visits and Six or More Well-Child Visits*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 3*
- Group F: Exclusions—All Medical Record Exclusions

Access and Risk-Adjusted Utilization Performance Measure Results

AlohaCare QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-2. All four measure rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure fell below the 25th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Hospitalization for Potentially Preventable Complications*; therefore, no prior years' rates or comparisons to national benchmarks are presented. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2020.

Table 3-2—AlohaCare QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	60.80%	61.35%	0.90%	★
45–64 Years	72.99%	73.90%	1.25%	★
65 Years and Older	80.58%	80.02%	-0.69%	★
Total	66.52%	67.47%	1.43%	★
Hospitalization for Potentially Preventable Complications				
Acute ACSC—Observed Discharges—Total	—	11.06	—	NC
Acute ACSC—O/E Ratio—Total	—	0.78	—	NC
Chronic ACSC—Observed Discharges—Total	—	24.92	—	NC
Chronic ACSC—O/E Ratio—Total	—	1.59	—	NC
Total ACSC—Observed Discharges—Total	—	35.99	—	NC
Total ACSC—O/E Ratio—Total	—	1.34	—	NC
Plan All-Cause Readmissions[1]				
*Index Total Stays—Observed Readmissions—Total**	—	8.37%	—	NC
*Index Total Stays—O/E Ratio—Total**	—	0.86	—	NC

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends a break in trending between HEDIS 2020 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile or above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Children's Preventive Health Performance Measure Results

AlohaCare QI's Children's Preventive Health performance measure results are shown in Table 3-3. Three rates in this domain demonstrated a relative improvement of more than 5 percent and three rates in this domain demonstrated a relative decline of more than 10 percent. One measure rate, *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, ranked at or above the 90th percentile. Conversely, 14 measure rates ranked below the 25th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2020 (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 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	50.61%	50.36%	-0.49%	★★
Childhood Immunization Status				
Combination 3	59.61%	64.48%	8.17%	★
DTaP	66.18%	69.83%	5.52%	★
Hepatitis B	78.59%	82.00%	4.34%	★
HiB	79.56%	81.27%	2.15%	★
IPV	81.75%	81.51%	-0.29%	★
MMR	78.59%	82.48%	4.95%	★
Pneumococcal Conjugate	66.67%	69.10%	3.64%	★
VZV	77.62%	81.51%	5.01%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	56.45%	54.26%	-3.88%	★
Combination 2 (Meningococcal, Tdap, HPV)	25.55%	20.68%	-19.06%	★
HPV	28.47%	25.55%	-10.26%	★
Meningococcal	59.12%	56.93%	-3.70%	★
Tdap	62.53%	62.77%	0.38%	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	0.73%	3.16%	332.88%	★
Six or More Well-Child Visits	73.48%	73.97%	0.67%	★★★★★
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	66.18%	67.88%	2.57%	★★

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.*
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 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. One rate in this domain demonstrated a relative decrease of more than 6 percent for HEDIS 2020. Two measure rates that could be compared to national benchmarks fell below the 25th percentile. Three measures[3-6] in this domain had an MQD Quality Strategy target for HEDIS 2020. 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 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	50.39%	47.15%	-6.43%	★
Cervical Cancer Screening[2]				
Cervical Cancer Screening	54.74%	54.50%	-0.44%	★
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	88.08%	—	NC
Postpartum Care	—	79.81%	—	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 2020, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.
[2] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.
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.
2020 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

AlohaCare QI's Care for Chronic Conditions performance measure results are shown in Table 3-5. One rate in this domain reported a relative improvement of more than 10 percent. Additionally, one rate in this domain reported a relative decrease of more than 15 percent. Three measure rates that could be compared to national benchmarks ranked at or above the 50th percentile and the other three measure rates fell below the 50th percentile. CY 2019 represented the first year for reporting the non-HEDIS measures *COPD or Asthma in Older Adults Admission Rate* and *Heart Failure Admission Rate*;

[3-6] Due to technical specification changes for HEDIS 2020, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Prenatal and Postpartum Care* measure.

therefore, no prior years' rates or comparisons to national benchmarks are presented. Five measures[3-7] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, and AlohaCare QI met the target for two of these measures: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)*.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	86.62%	88.08%	1.69%	★★
*HbA1c Poor Control (>9.0%)**	42.34%	35.28%	-16.67%	★★★
HbA1c Control (<8.0%)	47.20%	53.53%	13.41%	★★★
Eye Exam (Retinal) Performed	60.83%	58.64%	-3.60%	★★
Medical Attention for Nephropathy	86.62%	91.00%	5.06%	★★★
Blood Pressure Control (<140/90 mm Hg)	60.58%	59.85%	-1.21%	★★
COPD or Asthma in Older Adults Admission Rate				
40–64 Years	—	27.39	—	NC
65 Years and Older	—	172.51	—	NC
Total	—	56.51	—	NC
Heart Failure Admission Rate				
18–64 Years	—	60.08	—	NC
65 Years and Older	—	182.65	—	NC
Total	—	71.71	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** For this indicator, a lower rate indicates better performance.*
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 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. One rate reported a relative decline of more than 25 percent in HEDIS 2020. Additionally, three measure rates

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

that could be compared to national benchmarks ranked below the 25th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Screening, Brief Intervention, and Referral to Treatment*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Two measures[3-8] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, 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 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	18.69%	19.09%	2.14%	★
30-Day Follow-Up—Total	41.52%	38.79%	-6.58%	★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	29.73%	21.95%	-26.17%	★
Continuation and Maintenance Phase	NA	NA	—	NC
Screening, Brief Intervention, and Referral to Treatment				
SBIRT Training Plan Submitted to DHS/MQD	—	Met	—	NC
SBIRT Training Plan Recommendations from DHS/MQD Addressed	—	Met	—	NC
ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	—	Met	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
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.
Met indicates the health plan met the data element criteria.
— 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Conclusions and Recommendations

Based on HSAG's analyses of AlohaCare QI's 32 measure rates comparable to benchmarks, four measure rates (12.5 percent) ranked at or above the 50th percentile, with one of these rates (3.1 percent) ranking above the 90th percentile, indicating positive performance regarding controlling diabetes and well-child visits for infants.

[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*.

Conversely, 28 of AlohaCare QI's measure rates comparable to benchmarks (87.5 percent) fell below the 50th percentile, with 23 of these rates (71.9 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across most domains of care. Additionally, AlohaCare QI met two of the MQD Quality Strategy targets for HEDIS 2020. 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 and Risk-Adjusted Utilization
  - *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *45–64 Years*, *65 Years and Older*, and *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*
- Women's Health
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*
- Behavioral Health
  - *Follow-Up After Hospitalization 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

For validation year 2020, AlohaCare QI submitted two state-mandated PIPs for validation—*Improving Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness*. These rapid-cycle PIPs were implemented in July 2019. The PIP topics represent key areas of focus for improvement and are part of the MQD Quality Strategy.

Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. The focus of the *Improving Adolescent Well-Care Visits* PIP is to increase the percentage of adolescent well-care visits among 18 to 20-year-olds located in Waianae and Waipahu, and the focus of the *Follow-Up After Hospitalization for Mental Illness* PIP is to increase the percentage of compliance for seven-day follow-up visits after hospitalization for mental illness or intentional self-harm among members 18 to 64 years of age.

Findings

AlohaCare QI successfully achieved all validation criteria in Modules 1 through 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2020 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2021 annual validation.

For each PIP topic, in Module 1, AlohaCare QI determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global Aim and SMART Aim, and developed the key driver diagram. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. In Module 2, AlohaCare QI defined how and when it will be evident that improvement is being achieved.

Table 3-7 outlines AlohaCare QI's SMART Aim for each PIP.

Table 3-7—PIP Topic and SMART Aim Statements for AlohaCare QI

PIP Topic	SMART Aim Statement
Improving Adolescent Well-Care Visits	By January 31, 2021, increase the percentage of adolescent well-care visits among 18–20-year-olds located in Waianae and Waipahu from 14.92% to 17.71%.
Follow-Up After Hospitalization for Mental Illness	By January 31, 2021, increase the percentage of compliance for 7-day follow-up visits after hospitalization for mental illness or intentional self-harm among members 18–64 years of age from 15.5% to 21.4%.

In Module 3, the health plan determined potential interventions for the project. For each PIP, AlohaCare QI completed a process map and a failure modes and effects analysis (FMEA) to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 3-8 and Table 3-9 summarize the potential interventions AlohaCare QI identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 3-8—Intervention Determination Summary for the *Improving Adolescent Well-Care Visits* PIP for AlohaCare QI

Failure Modes	Potential Interventions
Member believes that he/she only needs to visit a provider when sick/injured.	• Provide the member educational material on adolescent well care (AWC) using technology (HealthCrowd), bilingual and interactive audio recordings, or texts. The message will describe who to schedule an AWC appointment with (primary care provider [PCP] or obstetrician/gynecologist [OB/GYN]) and why it is important. • Contact members who attended a sick visit but did not have an AWC visit within the measurement year and assist members with establishing care with their PCP.

Failure Modes	Potential Interventions
	• Provide provider education on "max-packing" acute sick/injured visit with an AWC visit.
Member does not schedule AWC visit with assigned PCP.	• Incentivize lead care managers (LCMs) who have successfully assisted with scheduling an appointment with a parent/guardian or member, and for the member who has completed an AWC visit during the measurement year. • Incentivize providers, office staff, and community health workers who have successfully assisted with scheduling an appointment with a parent/guardian or member, and the member who has completed an AWC visit during the measurement year.
Provider schedules visit with member, but member fails to attend.	• LCM and providers will use 1:1 text messaging capability/outreach calls to assist with appointment reminders to members. • Incentivize members who have successfully completed an AWC visit during the measurement year (e.g., gift cards, coupons, movie tickets, monthly raffles).

The health plan chose to test the "Develop and deploy a digital campaign through text/nanosite with content tailored for AWC outreach & education" intervention. Based on the intervention plan, the initial testing start date for this intervention was in April 2020; however, as per an update provided by the health plan in June 2020, the COVID-19 pandemic messaging took priority over developing content for PIP intervention text/nanosite and, therefore, the intervention testing was delayed until July 2020. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Table 3-9—Intervention Determination Summary for the *Follow-Up After Hospitalization for Mental Illness* PIP for AlohaCare QI

Failure Modes	Potential Interventions
Behavioral health practitioner (BHP) noted on list may be unavailable during critical 7-day follow-up window.	• Collaborate with clinics, organizations, and/or individuals statewide who could provide face-to-face (F2F) or telehealth follow-up visits within 7 days after discharge for members hospitalized with mental illness or intentional self-harm. • Establish secure methods for providing telehealth, such as ZOOM. For example, ZOOM via Transition of Care Behavioral Health Care Coordinator (ToC BH CC) laptop at the time of ToC BH CC pre-arranged post-discharge visit, who could then contact the BHP for a telehealth visit.
Member may not prioritize contacting BHP from list.	• ToC BH CC and facility case managers take a more active role with the member in discharge planning during inpatient hospitalization, assisting the member in making an appointment with established BHPs (if discharge date is known), instead of providing the member a list of BHPs (current process).

Failure Modes	Potential Interventions
	• Include in the inpatient discharge plan establishing with the member a definite date/time/place and method of contact within 24 hours of discharge to activate intervention #1 above (if discharge date is unknown).
Member may not call ToC BH CC at discharge.	• Include in the inpatient discharge plan ToC BH CC taking a more active role in establishing contact at discharge, such as confirming the member's address, telephone number, or other method of contact during the inpatient F2F visit (the current process is that the ToC BH CC gives the member a card containing his/her name and telephone number and instructs the member to contact the ToC BH CC at discharge, which puts the responsibility on the member to initiate contact). • Provide or assist in providing transportation for the member from the facility at discharge to the member's place of residence. This helps to ensure contact at discharge, as well as to confirm the member's contact information.
Member may not be aware of the importance of follow-up with a BHP within 7 days of discharge.	Include in the inpatient discharge plan providing education to the member regarding the importance of the 7-day follow-up visit with BHP, emphasizing that during the visit, the BHP can help the member address any concerns or need for further assistance, including but not limited to the following: • Assistance in obtaining medications as prescribed at the time of discharge, as well as assistance in meeting other current needs the member may have. • Assessment of the member's mental health status post-discharge. • Linking the member with case management or other services, as appropriate.

The health plan chose to test the "Collaborate with Care Hawaii (Care), a state-wide provider/organization, to provide face-to-face or telehealth follow-up visits by a Behavioral Health Practitioner (BHP) within 7 days after discharge for members hospitalized at Castle Medical Center (CMC) with mental illness or intentional self-harm" intervention. The health plan began testing this intervention in April 2020. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Strengths and Weaknesses

AlohaCare QI designed a methodologically sound project for both PIPs and was successful in building quality improvement teams and establishing collaborative partnerships. The health plan also successfully completed Module 3 and identified opportunities for improvement and potential interventions to address the identified flaws or gaps.

Recommendations for Improvement

Based on the 2020 PIP validation, HSAG recommends the following:

- AlohaCare QI should ensure that each intervention selected for testing is a change to the current process, will address identified flaws or gaps, and is expected to have a positive impact on the SMART Aim measure.
- When planning a test of change, AlohaCare QI should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- AlohaCare QI should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out when designing the intervention testing plan.
- To ensure a methodologically sound intervention testing methodology, AlohaCare QI should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- The health plan should document COVID-19 pandemic-related challenges in Module 4 and Module 5 submissions, and clearly indicate if any modifications were made to the interventions based on those challenges.
- AlohaCare QI should continue testing interventions for the PIP through the SMART Aim end date of January 31, 2021. AlohaCare QI should reach out to HSAG with any questions it has during this time.

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

The following is a summary of the adult CAHPS performance highlights for AlohaCare QI.

Findings

Table 3-10 presents the 2020 percentage of top-box responses for AlohaCare QI compared to the 2019 NCQA adult Medicaid national averages and the corresponding 2018 scores.[3-9,3-10] Additionally, the overall member experience ratings (i.e., star ratings) resulting from AlohaCare QI's top-box scores

[3-9] The adult population was not surveyed in 2019; therefore, the 2020 CAHPS scores could not be compared to the corresponding 2019 scores.

[3-10] National Committee for Quality Assurance. *HEDIS® 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2019.

compared to NCQA's 2019 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-11]

Table 3-10—Adult Medicaid CAHPS Results for AlohaCare QI

Measure	2018 Scores	2020 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	64.7%	63.2%	★★★
Rating of All Health Care	56.7%	53.9%	★★
Rating of Personal Doctor	67.5%	70.9%	★★★★
Rating of Specialist Seen Most Often	72.4%	69.6%	★★★
Composite Measures			
Getting Needed Care	84.1%	75.1% ▼	★
Getting Care Quickly	78.2%	74.4%	★
How Well Doctors Communicate	95.4%	93.9%	★★★★
Customer Service	93.3%+	87.7%	★★
Individual Item Measure			
Coordination of Care	88.8%+	86.2%+	★★★

Cells highlighted in yellow represent scores that are at or above the 2019 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2019 NCQA adult Medicaid national averages.
▲ Indicates the 2020 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2020 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

Strengths

For AlohaCare QI's adult Medicaid population, the following five measures met or exceeded the 2019 NCQA adult Medicaid national averages:

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

[3-11] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019.* Washington, DC: NCQA, September 2019.

Of the three MQD beneficiary experience Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—AlohaCare QI's member experience ratings 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*. AlohaCare QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-11 provides a summary of the key drivers identified for AlohaCare QI.

Table 3-11—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 it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.		✓	
Respondents reported that their health plan's customer service did not always give them the information or help they needed.	✓		**N/A**
N/A indicates that this question was not evaluated for this measure.			

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 not always easy to get the care, tests, or treatment they thought they needed through their health plan.

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

- Respondents reported that their health plan's customer service did not always give them the information or help they needed.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about 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, performance on outcome and process measures showed considerable room for improvement.

AlohaCare QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. AlohaCare QI's performance during the 2020 compliance review was above average, meeting or exceeding the statewide compliance score for seven of the eight standards. AlohaCare QI achieved 100 percent compliance in six standards, 95 percent in the *Subcontracts and Delegation* standard, and 90 percent in the *Provider Selection* standard. 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.

While policies, procedures, and staff were in place to monitor performance and promote quality, access, and timeliness of care, health plan performance indicators and member satisfaction scores were generally below the national Medicaid 50th percentile.

Overall, more than three-quarters (87.5 percent) of AlohaCare QI's measure rates fell below the 50th percentile across all domains, with more than two-thirds (71.9 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS 2019, AlohaCare QI's performance suggested several areas in need of improvement including the Access and Risk-Adjusted Utilization, Women's Health, and Behavioral Health domains, where all of the measure rates fell below the 25th percentile. Only two of AlohaCare QI's measure rates met the MQD Quality Strategy targets.

Similarly, AlohaCare QI's CAHPS results illustrate opportunities for improvement in members' experience. The following four measures were below the 50th percentile and scored below the 2019 NCQA adult Medicaid national averages: *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. Additionally, the following one measure scored statistically significantly lower in 2020 than in 2018: *Getting Needed Care.*

Finally, although final results for AlohaCare QI's PIPs were not available in 2020, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Improving Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness* rapid-cycle PIPs. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services.

Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

Compliance Monitoring Review

The 2020 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-12 presents the standards and compliance scores for HMSA QI.

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

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	10	0	0	0	100%
III	Credentialing	39	37	36	1	0	2	99%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	10	1	0	0	95%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**96**	**2**	**0**	**3**	**99%**

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

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

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

Overall, HMSA QI performed above average on the compliance review, scoring 100 percent on six of the eight standards reviewed in 2020.

Provider Selection:

HMSA QI had a comprehensive process for the selection of its network providers to sufficiently meet the needs of HMSA QI's members. Health plan documents demonstrated that HMSA QI communicated and supported network providers to advise and advocate for members regarding members' health status, medical care, treatment options, and the right to participate in treatment decisions. HMSA QI's provider training program informed providers about health plan operations, managed care, member rights and responsibilities, service coordination, claims, and utilization management (UM).

Subcontracts and Delegation:

HMSA QI had several executed subcontracts for various health plan administrative functions. The subcontracts included all required federal and State contract provisions. HMSA QI provided evidence of having conducted annual audits of its delegates reviewed under this standard. For those delegates, HMSA QI provided evidence of ongoing monitoring, which included regular review of reports from delegates and the use of a vendor scorecard to monitor performance. HMSA QI utilized ServiceNow, a vendor management tool, to store delegate contracts, track performance, review scorecards and operational deliverables, and track delegate audit dates.

Quality Assessment and Performance Improvement:

HMSA QI's QAPI program was supported by comprehensive plans and numerous policies that guided the health plan's care and service delivery system. Annually, HMSA QI prepared a QAPI program description, QAPI work plan, and QAPI program evaluation of the previous year's quality improvement program accomplishments. The robust QAPI work plan incorporated measurable goals, time frames, previously identified issues, and responsible staff members assigned to each quality improvement project. Further, the work plan served as the basis for the health plan's annual QAPI program evaluation. The annual evaluation validated the health plan's use of data, trending, and measurement against established goals, and included a narrative discussion of the health plan's accomplishments and any identified barriers that hindered goal achievement.

Health Information Systems:

HMSA QI demonstrated its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. HMSA QI had processes in place to verify the accuracy and completeness of its claims and encounter data by conducting claims audits and running the data through various system edits within its claims and encounter data reporting systems. The health plan also had data security measures, policies, and plans related to disaster planning and recovery and business continuity.

Practice Guidelines:

HMSA QI implemented processes for the adoption, review, and dissemination of CPGs. HMSA QI posted numerous CPGs for preventive health, behavioral health, and medical conditions, which included ADHD, cardiovascular disease and stroke—primary prevention, evaluation and management of chronic kidney disease, rheumatoid arthritis, and primary preventive service—children (perinatal to 19 years), in the Provider Resource Center Library. HMSA QI had processes in place to distribute the CPGs to members through regular member communications, mailings, or upon a member's request.

Enrollment and Disenrollment:

HMSA QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. As all member enrollment and disenrollment decisions were made by the State, HMSA QI customer service staff members referred health plan members to the State eligibility worker

in the event the member wanted to request disenrollment from the health plan. HMSA QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

HMSA QI was found to be 99 percent compliant with the Credentialing standard, with one element scoring a *Partially Met.* HMSA QI demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing individual providers that effectively evaluated providers and complied with the NCQA credentialing standards and guidelines. A review of credentialing and recredentialing files revealed that some organizational provider files were missing a completed application. The corrective action required by HMSA QI was to implement processes to ensure that the assessment and re-assessment process for organizational providers is followed as outlined in HMSA QI's policy; specifically, that an application is completed and submitted to HMSA QI from the organizational provider.

HMSA QI was found to be 95 percent compliant with the Program Integrity standard, with one element scoring a *Partially Met*. HMSA QI had a compliance plan and several policies and procedures that guided the health plan's compliance program. HMSA QI had processes in place to report overpayments due to FWA promptly using the State's reporting templates. While HMSA QI could speak to a general process for reconciling capitation payments from the State against eligibility files, it did not have any written policy, procedure, or process in place to report to the State, or require subcontractors to report to the State, within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract. HMSA QI's required corrective action was to develop and implement a written policy, procedure, and/or process to report capitation overpayments to the State.

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 three standard supplemental data sources and three non-standard sources for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2020 measure reporting. All convenience samples passed HSAG's review.

Based on HMSA QI's data systems and processes, the auditors recommended that the data from 'Ohana, which is contracted to provide behavioral health services for members, be incorporated for any future HEDIS or state-specific measure rate reporting.

All QI measures that HMSA QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted for the measure.

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

- Group A: Biometrics (BMI, BP) & Maternity—*Prenatal and Postpartum Care—Postpartum Care*
- Group B: Anticipatory Guidance & Counseling—*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 3*

Access and Risk-Adjusted Utilization Performance Measure Results

HMSA QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-13. Overall, all four measure rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure ranked below the 50th percentile, and two of these measure rates fell below the 25th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Hospitalization for Potentially Preventable Complications*; therefore, no prior years' rates or comparisons to national benchmarks are presented. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2020.

Table 3-13—HMSA QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	71.21%	71.22%	0.01%	★
45–64 Years	81.95%	81.75%	-0.24%	★★
65 Years and Older	84.90%	85.97%	1.26%	★★
Total	75.53%	75.70%	0.23%	★
Hospitalization for Potentially Preventable Complications				
Acute ACSC—Observed Discharges—Total	—	8.65	—	NC
Acute ACSC—O/E Ratio—Total	—	—	—	NC
Chronic ACSC—Observed Discharges—Total	—	20.06	—	NC
Chronic ACSC—O/E Ratio—Total	—	—	—	NC
Total ACSC—Observed Discharges—Total	—	28.72	—	NC
Total ACSC—O/E Ratio—Total	—	—	—	NC

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Plan All-Cause Readmissions[1]				
*Index Total Stays—Observed Readmissions—Total**	—	9.26%	—	NC
*Index Total Stays—O/E Ratio—Total**	—	0.92	—	NC

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends a break in trending between HEDIS 2020 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Children's Preventive Health Performance Measure Results

HMSA QI's Children's Preventive Health performance measure results are shown in Table 3-14. Three measure rates in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2020. Additionally, four measure rates ranked at or above the 50th percentile. Conversely, 13 measures fell below the 50th percentile, with five measures ranking below the 25th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2020 (i.e., *Childhood Immunization Status—Combination 3)*, and HMSA QI did not meet the established target, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	52.80%	59.76%	13.18%	★★★
Childhood Immunization Status				
Combination 3	71.53%	65.94%	-7.81%	★★
DTaP	77.86%	74.21%	-4.69%	★★
Hepatitis B	86.13%	80.29%	-6.78%	★
HiB	88.32%	87.59%	-0.83%	★★
IPV	87.10%	83.21%	-4.47%	★
MMR	89.05%	88.81%	-0.27%	★★★
Pneumococcal Conjugate	76.64%	75.67%	-1.27%	★★
VZV	86.62%	87.35%	0.84%	★★

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	66.42%	69.34%	4.40%	★
Combination 2 (Meningococcal, Tdap, HPV)	28.71%	33.09%	15.26%	★★
HPV	31.63%	36.25%	14.61%	★★
Meningococcal	69.59%	71.29%	2.44%	★
Tdap	70.80%	76.64%	8.25%	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	1.72%	1.72%	0.00%	★★
Six or More Well-Child Visits	71.26%	71.26%	0.00%	★★★★
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	71.18%	76.42%	7.36%	★★★

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.*
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Women's Health Performance Measure Results

HMSA QI's Women's Health performance measure results are shown in Table 3-15. One rate in this domain reported a relative improvement of more than 7 percent in HEDIS 2020. One measure ranked at or above the 75th percentile and one measure ranked at or above the 50th percentile. Three measures[3-12] in this domain had an MQD Quality Strategy target for HEDIS 2020. HMSA QI's measure rate for *Cervical Cancer Screening* met or exceeded the established MQD Quality Strategy target.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	60.23%	58.86%	-2.27%	★★★
Cervical Cancer Screening[2]				
Cervical Cancer Screening	63.30%	68.13%	7.63%	★★★★

[3-12] Due to technical specification changes for HEDIS 2020, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Prenatal and Postpartum Care* measure.

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	77.62%	—	NC
Postpartum Care	—	55.72%	—	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 2020, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.
[2] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Care for Chronic Conditions Performance Measure Results

HMSA QI's Care for Chronic Conditions performance measure results are shown in Table 3-16. One rate in this domain demonstrated a relative improvement of more than 20 percent in HEDIS 2020. Additionally, one measure rate ranked at or above the 75th percentile. Conversely five measures ranked below the 50th percentile, with one measure rate falling below the 25th percentile. CY 2019 represented the first year for reporting the non-HEDIS measures *COPD or Asthma in Older Adults Admission Rate* and *Heart Failure Admission Rate*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Five measures[3-13] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, and HMSA QI met the target for one measure: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	87.35%	85.40%	-2.23%	★★
*HbA1c Poor Control (>9.0%)**	42.82%	40.39%	-5.67%	★★
HbA1c Control (<8.0%)	43.80%	47.69%	8.88%	★★
Eye Exam (Retinal) Performed	67.15%	66.91%	-0.36%	★★★★

[3-13] Within this domain, there were five 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)*.

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Medical Attention for Nephropathy	89.54%	86.37%	-3.54%	★
Blood Pressure Control (<140/90 mm Hg)	48.66%	59.12%	21.50%	★★
COPD or Asthma in Older Adults Admission Rate				
40–64 Years	—	41.47	—	NC
65 Years and Older	—	59.45	—	NC
Total	—	43.48	—	NC
Heart Failure Admission Rate				
18–64 Years	—	37.13	—	NC
65 Years and Older	—	97.10	—	NC
Total	—	40.14	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** For this indicator, a lower rate indicates better performance.*
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Behavioral Health Performance Measure Results

HMSA QI's Behavioral Health performance measure results are shown in Table 3-17. One rate in this domain demonstrated a relative improvement of more than 10 percent for HEDIS 2020. Conversely, two measure rates in this domain demonstrated a relative decline of more than 10 percent for HEDIS 2020. Additionally, all four rates that could be compared to national benchmarks met or exceeded the 50th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Screening, Brief Intervention, and Referral to Treatment*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Two measures[3-14] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, and HMSA QI did not reach the established targets, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	35.32%	38.69%	9.54%	★★★

[3-14] 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 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
30-Day Follow-Up—Total	53.82%	59.64%	10.81%	★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	51.92%	46.20%	-11.02%	★★★
Continuation and Maintenance Phase	66.67%	57.14%	-14.29%	★★★
Screening, Brief Intervention, and Referral to Treatment				
SBIRT Training Plan Submitted to DHS/MQD	—	Met	—	NC
SBIRT Training Plan Recommendations from DHS/MQD Addressed	—	Met	—	NC
ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	—	Met	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.
Met indicates the health plan met the data element criteria.
— 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Conclusions and Recommendations

Based on HSAG's analyses of HMSA QI's 33 measure rates comparable to benchmarks, 11 measure rates (33.3 percent) ranked at or above the 50th percentile, with three of these rates (9.1 percent) ranking above the 75th percentile, indicating positive performance in well-child visits for infants; appropriate screening for cervical cancer; and appropriate eye exams for diabetic members. Additionally, HMSA QI met two of the MQD Quality Strategy targets for HEDIS 2020.

Conversely, 22 of HMSA QI's measure rates comparable to benchmarks (68.7 percent) fell below the 50th percentile, with eight of these rates (24.2 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 and Risk-Adjusted Utilization
  - *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* and *Total*
- Children's Preventive Health
  - *Childhood Immunization Status—Hepatitis B* and *IPV*
  - *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*, *Meningococcal*, and *Tdap*

- Care for Chronic Conditions
  - *Comprehensive Diabetes Care—Medical Attention for Nephropathy*

Validation of Performance Improvement Projects

For validation year 2020, HMSA QI submitted the following topics for validation: *Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness*. These rapid-cycle PIPs were implemented in July 2019. The PIP topics represent key areas of focus for improvement and are part of the MQD Quality Strategy.

Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. The focus of the *Adolescent Well-Care Visits* PIP is to increase the percentage of adolescent well-care visits among 12 to 21-year-olds located in Kauai County. The focus of the *Follow-Up After Hospitalization for Mental Illness* PIP is to increase the percentage of compliance for seven-day follow-up visits after hospitalization for mental illness or intentional self-harm among members 18 years and older.

Findings

HMSA QI successfully achieved all validation criteria in Modules 1 through 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2020 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2021 annual validation.

For each PIP topic, in Module 1, HMSA QI determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global Aim and SMART Aim, and developed the key driver diagram. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. In Module 2, HMSA QI defined how and when it will be evident that improvement is being achieved.

Table 3-18 outlines HMSA QI's SMART Aim for each PIP.

Table 3-18—PIP Topic and SMART Aim Statements for HMSA QI

PIP Topic	SMART Aim Statement
Adolescent Well-Care Visits	By January 31, 2021, for members 12 to 21 years of age and older in Kauai County, increase the overall percentage of adolescent well-care visits from 38% to 41%.
Follow-Up After Hospitalization for Mental Illness	By January 31, 2021, for acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm, increase the total percentage of follow-up visits with a mental health practitioner after hospitalization for mental illness within 7 days after discharge from 34.72% to 37.72%.

In Module 3, the health plan determined potential interventions for the project. For each PIP, HMSA QI completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 3-19 and Table 3-20 summarize the potential interventions HMSA QI identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 3-19—Intervention Determination Summary for the *Adolescent Well-Care Visits* PIP for HMSA QI

Failure Modes	Potential Interventions
Member is not aware of the annual adolescent well-care visit benefit.	Targeted member education and incentives for completed adolescent well-care visits.
Value of the visit is not understood by the parent, guardian, or adolescent.	Improve adolescent well-care visit messaging in Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mailings.
Member is not aware of the transportation benefit.	Develop and distribute member educational material that describes the EPSDT transportation benefit and how to access transportation services.
Member is not aware of how to access the transportation benefit.	Develop and distribute member educational material that describes the EPSDT transportation benefit and how to access transportation services.

The health plan chose to test the "Targeted member incentive and education" intervention. Based on the intervention plan, the initial testing start date for this intervention was in June 2020; however, due to the COVID-19 pandemic, there were delays in initiating the intervention. The health plan anticipated to begin targeted member outreach in September 2020. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Table 3-20—Intervention Determination Summary for the *Follow-Up After Hospitalization for Mental Illness* PIP for HMSA QI

Failure Modes	Potential Interventions
Members cannot be contacted by telephone.	• Use external sources such as triage sheets, provider information, etc., to find updated contact numbers. • Identify whether members can be contacted via email, text, or letter.
Members are scheduled for appointments greater than 7 days post-discharge.	• Educate facilities about the *FUH* measure and encourage them to set up an additional appointment within 7 days of discharge. • Assist members with obtaining telehealth appointments. • Perform transition of care activities with members within 2 business days of discharge.
Members are readmitted within 30 days of discharge.	• Assist members post-discharge through service coordination. • Connect members with community resources for crisis management.

The health plan chose to test the "Work with behavioral health practitioners while member is inpatient to get scheduled ahead of discharge" intervention. Based on the intervention plan, the health plan initiated

this intervention in July 2020 and continues to test this intervention. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Strengths and Weaknesses

HMSA QI designed a methodologically sound project for both PIPs and was successful in building quality improvement teams and establishing collaborative partnerships. The health plan also successfully completed Module 3 and identified opportunities for improvement and potential interventions to address the identified flaws or gaps.

Recommendations for Improvement

Based on the 2020 PIP validation, HSAG recommends the following:

- HMSA QI should ensure that each intervention selected for testing is a change to the current process, will address identified flaws or gaps, and is expected to have a positive impact on the SMART Aim measure.
- When planning a test of change, HMSA QI should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- HMSA QI should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out when designing the intervention testing plan.
- To ensure a methodologically sound intervention testing methodology, HMSA QI should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- The health plan should document COVID-19 pandemic-related challenges in Module 4 and Module 5 submissions, and clearly indicate if any modifications were made to the interventions based on those challenges.
- HMSA QI should continue testing interventions for the PIP through the SMART Aim end date of January 31, 2021. HMSA QI should reach out to HSAG with any questions it has during this time.

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

The following is a summary of the adult CAHPS performance highlights for HMSA QI.

Findings

Table 3-21 presents the 2020 percentage of top-box responses for HMSA QI compared to the 2019 NCQA adult Medicaid national averages and the corresponding 2018 scores.[3-15,3-16] Additionally, the overall member experience ratings (i.e., star ratings) resulting from HMSA QI's top-box scores compared to NCQA's 2019 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-17]

Table 3-21—Adult Medicaid CAHPS Results for HMSA QI

Measure	2018 Scores	2020 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	58.5%	57.6%	★★
Rating of All Health Care	56.3%	50.9%	★
Rating of Personal Doctor	62.0%	61.3%	★
Rating of Specialist Seen Most Often	62.6%	60.4%	★
Composite Measures			
Getting Needed Care	82.1%	75.1% ▼	★
Getting Care Quickly	79.5%	75.2%	★
How Well Doctors Communicate	91.8%	92.7%	★★★
Customer Service	92.6%+	79.8% ▼	★
Individual Item Measure			
Coordination of Care	85.9%	81.0%	★

Cells highlighted in yellow represent scores that are at or above the 2019 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2019 NCQA adult Medicaid national averages.
▲ Indicates the 2020 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2020 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

3-15 The adult population was not surveyed in 2019; therefore, the 2020 CAHPS scores could not be compared to the corresponding 2019 scores.
3-16 National Committee for Quality Assurance. *HEDIS® 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2019.
3-17 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

Strengths

For HMSA QI's adult Medicaid population, one measure met or exceeded the 2019 NCQA adult Medicaid national average, *How Well Doctors Communicate*.

None of the three MQD beneficiary experience Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—met or exceeded the 75th percentile for HMSA 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*. HMSA QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-22 provides a summary of the key drivers identified for HMSA QI.

Table 3-22—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 they 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 they needed through their health plan.		✓	
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.		✓	✓
Respondents reported that their health plan's customer service did not always give them the information or help they needed.	✓		**N/A**
Respondents reported that forms from their health plan were often not easy to fill out.	✓		**N/A**
N/A indicates that this question was not evaluated for this measure.			

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 they 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 they 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 HMSA QI:

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

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, performance on outcome and process measures showed considerable room for improvement.

HMSA QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. HMSA QI's performance during the 2020 compliance review was above average, meeting or exceeding the statewide compliance score for seven of the eight standards. HMSA QI achieved 100 percent compliance in six standards, 99 percent in the *Credentialing* standard, and 95 percent in the *Program Integrity* standard. 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.

While policies, procedures, and staff were in place to monitor performance and promote quality, access, and timeliness of care, health plan performance indicators and member satisfaction scores were generally below the national Medicaid 50th percentile.

Overall, two-thirds (66.7 percent) of HMSA QI's measures fell below the 50th percentile across all domains, with nearly one-quarter (24.2 percent) of measure rates falling below the 25th percentile. While some measure rates showed improvement from HEDIS 2019, HMSA QI's performance suggested several areas in need of improvement including the Access and Risk-Adjusted Utilization, Children's Preventive Health, and Care for Chronic Conditions domains. Overall, only two of the MQD Quality Strategy targets were met in HEDIS 2020.

Similarly, HMSA QI's CAHPS results illustrate opportunities for improvement in members' experience. The following eight measures were below the 50th percentile and scored below the 2019 NCQA adult Medicaid national averages: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Coordination of Care*. Additionally, the following two measures scored statistically significantly lower in 2020 than in 2018: *Getting Needed Care* and *Customer Service*.

Finally, although final results for HMSA QI's PIPs were not available in 2020, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness* rapid-cycle PIPs. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

Compliance Monitoring Review

The 2020 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-23 presents the standards and compliance scores for KFHP QI.

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

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	4	1	0	1	90%
II	Subcontracts and Delegation	10	10	4	6	0	0	70%
III	Credentialing	39	37	36	1	0	2	99%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	9	2	0	0	91%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**88**	**10**	**0**	**3**	**95%**

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

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

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

Strengths

KFHP QI scored 100 percent on four of the eight compliance standards reviewed in 2020.

Quality Assessment and Performance Improvement:

KFHP QI's QAPI program was supported by both national and regional quality structures, comprehensive plans, and numerous policies that guided the health plan's care and service delivery system and provided the framework through which monitoring and improvement activities were conducted. KFHP QI had an established integrated quality program wherein quality assurance and systems improvement were shared responsibilities of KFHP QI, Kaiser Health Foundation (KHF), and

Hawaii Permanente Medical Group (HPMG). The QAPI work plan incorporated measurable goals, time frames, measurement source, and responsible staff members assigned to each quality improvement objective. Further, the work plan served as the basis for the health plan's annual QAPI program evaluation. To support population-based primary and secondary preventive care, the Hawaii Region developed a chronic disease and patient-based decision support system. Use of this tool allows the primary care physician to closely monitor chronic disease members' progress in meeting specified quality goals for disease management.

Health Information Systems:

KFHP QI demonstrated its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. KFHP QI also had processes in place to verify the accuracy and completeness of its claims and encounter data by running the data through various system edits within its claims systems and implementing the National Medicaid Encounter Data Reporting System in 2019. With the assistance of local, regional, and national information technology departments, KFHP QI implemented several data security measures and policies and plans related to disaster planning and recovery and business continuity.

Practice Guidelines:

KFHP QI adopted both national-level and Hawaii Region CPGs. Topics included medical and behavioral health conditions, as well as preventive healthcare guidelines for adults and children. The process for selection, adoption, dissemination, and implementation of CPGs was described in policies and procedures and was incorporated into the program descriptions for both quality and UM. The health plan had processes for regular dissemination of CPG information to providers through a provider intranet, and dissemination of CPGs to members occurred upon request through KFHP QI's customer service center.

Enrollment and Disenrollment:

KFHP QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. As all member enrollment and disenrollment decisions were made by the State, KFHP QI customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. KFHP QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

KFHP QI was found to be 99 percent compliant with the Credentialing standard, with one element scoring a *Partially Met*. KFHP QI had processes for credentialing and recredentialing licensed independent practitioners and allied health practitioners that aligned with the NCQA standards and guidelines. A review of assessment and re-assessment of organizational provider files revealed that the

health plan did not collect the CMS or Hawaii State Department of Health (DOH) quality review report as required in the health plan's policy. The corrective action required by KFHP QI was to develop a mechanism to ensure that State or CMS surveys are received and meet KFHP QI's quality guidelines for assessments or re-assessments of organizational providers that are not accredited and are conducted in lieu of KFHP QI conducting the on-site review.

KFHP QI was found to be 91 percent compliant with the Program Integrity standard, with two elements scoring *Partially Met*. KFHP QI had a compliance plan and several policies and procedures that guided the health plan's compliance program. KFHP QI provided initial onboarding and annual training to employees about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security. While KFHP QI could speak to a general process for reconciling capitation payments from the State against eligibility files, it did not have any written policy, procedure, or process in place to report to the State, or require subcontractors to report to the State, within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract. In addition, KFHP QI did not provide information to providers regarding the process for notifying and returning an overpayment to the health plan. KFHP QI's required corrective actions were to develop and implement a written policy, procedure, and/or process to report capitation overpayments to the State and to revise its provider agreements and/or provider manual to inform providers of the requirement and process to report overpayments to the health plan.

KFHP QI was found to be 90 percent compliant with the Provider Selection standard, with one element scoring a *Partially Met.* Overall, KFHP QI had a process for the selection of its network providers to sufficiently meet the needs of its QI members. However, the health plan's credentialing policy was missing key provisions and timelines for notifying providers and the State when a provider or group is declined participation in the network. The corrective action required by KFHP QI was to ensure that mechanisms are in place to provide written notice of the reason for the health plan's decision to decline an individual or groups of providers in its network to affected providers at least 30 days prior to the effective date and notify DHS at least 45 days prior to the effective date if the individuals or providers represent 5 percent or more of the total providers in that specialty, or if it is a hospital.

KFHP QI was found to be 70 percent compliant with the Subcontracts and Delegation standard, with six elements scoring a *Partially Met*. The health plan had several executed subcontracts for various health plan administrative functions. The subcontracts were missing required federal and State provisions and KFHP QI did not have processes for pre-delegation assessments, and ongoing monitoring and formal auditing of its delegates. KFHP QI's required actions included developing policies and procedures for monitoring and auditing its delegates and executing revised subcontracts that include all required contract provisions.

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 2020 measure reporting. All convenience samples passed HSAG's review.

The auditors did not have any recommendations for KFHP QI.

All QI measures that KFHP QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted. For KFHP QI reporting, the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicator 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—*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Prenatal and Postpartum Care—Postpartum Care*
- Group D: Immunization & Other Screenings—*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- Group F: Exclusions—All Medical Record Exclusions

Access and Risk-Adjusted Utilization Performance Measure Results

KFHP QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-24. Overall, all four measures rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure ranked at or above the 50th percentile, with one of these rates exceeding the 75th percentile and another rate exceeding the 90th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Hospitalization for Potentially Preventable Complications*; therefore, no prior years' rates or comparisons to national benchmarks are presented. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2020.

Table 3-24—KFHP QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	80.68%	80.05%	-0.78%	★★★
45–64 Years	90.07%	90.20%	0.14%	★★★★
65 Years and Older	96.68%	95.82%	-0.89%	★★★★★
Total	85.10%	84.91%	-0.22%	★★★
Hospitalization for Potentially Preventable Complications				
Acute ACSC—Observed Discharges—Total	—	19.15	—	NC
Acute ACSC—O/E Ratio—Total	—	0.76	—	NC
Chronic ACSC—Observed Discharges—Total	—	20.62	—	NC
Chronic ACSC—O/E Ratio—Total	—	0.83	—	NC
Total ACSC—Observed Discharges—Total	—	39.71	—	NC
Total ACSC—O/E Ratio—Total	—	0.95	—	NC
Plan All-Cause Readmissions[1]				
*Index Total Stays—Observed Readmissions—Total**	—	10.12%	—	NC
*Index Total Stays—O/E Ratio—Total**	—	1.03	—	NC

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends a break in trending between HEDIS 2020 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Children's Preventive Health Performance Measure Results

KFHP QI's Children's Preventive Health performance measure results are shown in Table 3-25. One rate in this domain demonstrated a relative improvement of more than 25 percent in HEDIS 2020. Overall, eight measure rates ranked at or above the 75th percentile, with three of these rates exceeding the 90th percentile. Additionally, six measure rates ranked at or above the 50th percentile. Conversely, three measure rates fell below the 50th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2020 (i.e., *Childhood Immunization Status—Combination 3*), and KFHP QI exceeded the established target, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	42.34%	45.28%	6.94%	★★
Childhood Immunization Status				
Combination 3	81.17%	79.45%	-2.12%	★★★★★
DTaP	83.50%	82.51%	-1.19%	★★★★
Hepatitis B	92.26%	90.82%	-1.56%	★★★
HiB	90.07%	87.32%	-3.05%	★★
IPV	91.68%	90.52%	-1.27%	★★★
MMR	90.80%	91.25%	0.50%	★★★★
Pneumococcal Conjugate	82.34%	80.03%	-2.81%	★★★
VZV	90.51%	90.52%	0.01%	★★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	83.98%	83.22%	-0.90%	★★★
Combination 2 (Meningococcal, Tdap, HPV)	47.08%	43.94%	-6.67%	★★★★
HPV	47.63%	44.87%	-5.79%	★★★★
Meningococcal	85.24%	84.29%	-1.11%	★★★
Tdap	86.35%	85.35%	-1.16%	★★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	0.46%	0.33%	-28.26%	★★★★★
Six or More Well-Child Visits	74.92%	79.28%	5.82%	★★★★★
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	86.53%	82.99%	-4.09%	★★★★

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.*
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Women's Health Performance Measure Results

KFHP QI's Women's Health performance measure results are shown in Table 3-26. Both measure rates that could be compared to national benchmarks exceeded the 90th percentile. Three measures[3-18] in this

[3-18] Due to technical specification changes for HEDIS 2020, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Prenatal and Postpartum Care* measure.

domain had an MQD Quality Strategy target for HEDIS 2020, and KFHP QI met or exceeded two of the established MQD Quality Strategy targets, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	79.03%	80.87%	2.33%	★★★★★
Cervical Cancer Screening[2]				
Cervical Cancer Screening	78.51%	78.73%	0.28%	★★★★★
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	99.26%	—	NC
Postpartum Care	—	87.62%	—	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 in HEDIS 2020, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.
[2] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Care for Chronic Conditions Performance Measure Results

KFHP QI's Care for Chronic Conditions performance measure results are shown in Table 3-27. Six measure rates that could be compared to national benchmarks ranked at or above the 75th percentile, with five of six measure rates exceeding the 90th percentile. CY 2019 represented the first year for reporting the non-HEDIS measures *COPD or Asthma in Older Adults Admission Rate* and *Heart Failure Admission Rate*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Five measures[3-19] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, and KFHP QI met the target for all five of these measures.

[3-19] Within this domain, there were five 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)*.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	94.59%	95.01%	0.44%	★★★★★
*HbA1c Poor Control (>9.0%)**	33.11%	29.00%	-12.41%	★★★★
HbA1c Control (<8.0%)	56.16%	61.45%	9.42%	★★★★★
Eye Exam (Retinal) Performed	66.91%	69.83%	4.36%	★★★★★
Medical Attention for Nephropathy	95.20%	95.74%	0.57%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	79.08%	80.29%	1.53%	★★★★★
COPD or Asthma in Older Adults Admission Rate				
40–64 Years	—	22.11	—	NC
65 Years and Older	—	45.11	—	NC
Total	—	25.53	—	NC
Heart Failure Admission Rate				
18–64 Years	—	40.17	—	NC
65 Years and Older	—	126.31	—	NC
Total	—	46.13	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** For this indicator, a lower rate indicates better performance.*
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 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 3-28. One rate reported a relative decline of more than 10 percent in HEDIS 2020. Three measure rates that could be compared to national benchmarks exceeded the 90th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Screening, Brief Intervention, and Referral to Treatment*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Two measures[3-20] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, and KFHP QI met or exceeded both of the established targets, the 75th percentile.

[3-20] 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*.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	56.64%	60.31%	6.48%	★★★★★
30-Day Follow-Up—Total	68.14%	73.28%	7.54%	★★★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	74.36%	65.98%	-11.27%	★★★★★
Continuation and Maintenance Phase	NA	NA	—	NC
Screening, Brief Intervention, and Referral to Treatment				
SBIRT Training Plan Submitted to DHS/MQD	—	Met	—	NC
SBIRT Training Plan Recommendations from DHS/MQD Addressed	—	Met	—	NC
ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	—	Met	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
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.
Met indicates the health plan met the data element criteria.
— 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Conclusions and Recommendations

Based on HSAG's analyses of KFHP QI's 32 measure rates comparable to benchmarks, 29 measure rates (90.6 percent) ranked at or above the 50th percentile, with 14 of these rates (43.8 percent) exceeding the 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met 10 of the MQD Quality Strategy targets for HEDIS 2019: *Childhood Immunization Status—Combination 3*; *Breast Cancer Screening*; *Cervical Cancer Screening*; *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)*; and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*.

Conversely, three of KFHP QI's measure rates comparable to benchmarks (9.4 percent) fell below the 50th 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 50th percentile for the QI population:

- Children's Preventive Health
  - *Adolescent Well-Care Visits*
  - *Childhood Immunization Status—HiB*
  - *Immunizations for Adolescents—Tdap*

Validation of Performance Improvement Projects

For validation year 2020, KFHP QI submitted two state-mandated PIPs for validation—*Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness*. These rapid-cycle PIPs were implemented in July 2019. The PIP topics represent key areas of focus for improvement and are part of the MQD Quality Strategy.

Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. The focus of the *Adolescent Well-Care Visits* PIP is to increase the percentage of adolescent well-care visits among 12 to 21-year-olds assigned to a PCP at the Waipio Clinic. The focus of the *Follow-Up After Hospitalization for Mental Illness* PIP is to increase the percentage of compliance for seven-day follow-up visits after hospitalization for mental illness or intentional self-harm among members 6 years and older in Oahu and Maui.

Findings

KFHP QI successfully achieved all validation criteria in Modules 1 through 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2020 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2021 annual validation.

For each PIP topic, in Module 1, KFHP QI determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global Aim and SMART Aim, and developed the key driver diagram. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. In Module 2, KFHP QI defined how and when it will be evident that improvement is being achieved.

Table 3-29 outlines KFHP QI's SMART Aim for each PIP.

Table 3-29—PIP Topic and SMART Aim Statements for KFHP QI

PIP Topic	SMART Aim Statement
Adolescent Well-Care Visits	By January 31, 2021, increase the percentage of completed adolescent well-care visits among QUEST Integration members ages 12–21 who are assigned to a primary care physician (PCP) at the Waipio Clinic from 45.46% to 48.42%.

PIP Topic	SMART Aim Statement
Follow-Up After Hospitalization for Mental Illness	By January 31, 2021, increase our percentile ranking for the *Follow-Up After Hospitalization for Mental Illness* measure from the 75th percentile to the 95th percentile range by increasing the percentage of completed follow-up visits with a mental health practitioner within 30 days after an acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm for QUEST Integration members on Oahu and Maui, ages 6 and older, from 68.14% to 75.68% or higher.

The objective of Module 3 is for the health plan to determine potential interventions for the project. For each PIP, KFHP QI completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 3-30 and Table 3-31 summarize the potential interventions KFHP QI identified to address high priority subprocesses and failure modes determined in Module 3.

Table 3-30—Intervention Determination Summary for the *Adolescent Well-Care Visits* PIP for KFHP QI

Failure Modes	Potential Interventions
Staff do not know how to use the "Well-Child Visit" tool.	Educate staff on how to use the 'Well-Child Visit" tool to identify members who are due for a visit.
Member is not routinely placed on the wait list.	Use the "Well-Child Visit" tool to identify members and place them on the wait list for an appropriate due date.
Unable to contact member via a telephone call.	Use text messaging to confirm the appointment.
Demographic information is incorrect or outdated.	Educate staff to assure information is updated with each contact.

The health plan chose to test the "Use the WCV tool to add members to the wait list for appropriate due date" intervention. The health plan initiated intervention testing in June 2020; however, due to COVID-19 pandemic-related challenges, the health plan documented loss of clerical support for scheduling routine well-care visits for members from the wait list and the intervention was abandoned in July 2020. The health plan initiated a second intervention, "Outreaching and scheduling members from the outreach list created from WCV tool," in August 2020 and is continuing to test this intervention. In the second intervention, rather than adding members to the wait list to be scheduled by clerical support staff members, the health plan will test the process of scheduling well-child visits by clinical staff members. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2020.

Table 3-31—Intervention Determination Summary for the *Follow-Up After Hospitalization for Mental Illness* PIP for KFHP QI

Failure Modes	Potential Interventions
Member does not keep follow-up appointment.	Provide live reminder calls two days after discharge.

Failure Modes	Potential Interventions
Unable to contact the member to reschedule a missed appointment or the member does not respond to messages/letter.	• Update member contact information prior to discharge. • Provide appointment information at discharge (i.e., "you will receive a reminder call two days after discharge about your follow-up appointment").
Member is not engaged or interested.	Provide education about the importance of a follow-up appointment during the live reminder call.

The health plan chose to test the "Provide live reminder call prior to scheduled hospital discharge appointment" intervention. The health plan initiated the intervention in May 2020. The intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Strengths and Weaknesses

KFHP QI designed a methodologically sound project for both PIPs and was successful in building quality improvement teams and establishing collaborative partnerships. The health plan also successfully completed Module 3 and identified opportunities for improvement and potential interventions to address the identified flaws or gaps.

Recommendations for Improvement

Based on the 2020 PIP validation, HSAG recommends the following:

- KFHP QI should ensure that each intervention selected for testing is a change to the current process, will address identified flaws or gaps, and is expected to have a positive impact on the SMART Aim measure.
- When planning a test of change, KFHP QI should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- KFHP QI should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out when designing the intervention testing plan.
- To ensure a methodologically sound intervention testing methodology, KFHP QI should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- The health plan should document COVID-19 pandemic-related challenges in Module 4 and Module 5 submissions, and clearly indicate if any modifications were made to the interventions based on those challenges.

KFHP QI should continue testing interventions for the PIP through the SMART Aim end date of January 31, 2021. KFHP QI should reach out to HSAG with any questions it has during this time.

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

The following is a summary of the adult CAHPS performance highlights for KFHP QI.

Findings

Table 3-32 presents the 2020 percentage of top-box responses for KFHP QI compared to the 2019 NCQA adult Medicaid national averages and the corresponding 2018 scores.[3-21,3-22] Additionally, the overall member experience ratings (i.e., star ratings) resulting from KFHP QI's top-box scores compared to NCQA's 2019 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-23]

Table 3-32—Adult Medicaid CAHPS Results for KFHP QI

Measure	2018 Scores	2020 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	71.7%	69.8%	★★★★★
Rating of All Health Care	60.3%	67.5% ▲	★★★★★
Rating of Personal Doctor	70.5%	73.5%	★★★★
Rating of Specialist Seen Most Often	68.6%	75.5%	★★★★★
Composite Measures			
Getting Needed Care	83.4%	86.2%	★★★★
Getting Care Quickly	82.1%	82.5%	★★★
How Well Doctors Communicate	95.4%	96.6%	★★★★★
Customer Service	88.5%	90.9%	★★★
Individual Item Measure			
Coordination of Care	85.6%	94.8% ▲	★★★★★

Cells highlighted in yellow represent scores that are at or above the 2019 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2019 NCQA adult Medicaid national averages.
▲ Indicates the 2020 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2020 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

3-21 The adult population was not surveyed in 2019; therefore, the 2020 CAHPS scores could not be compared to the corresponding 2019 scores.

3-22 National Committee for Quality Assurance. *HEDIS® 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2019.

3-23 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

Strengths

For KFHP QI's adult Medicaid population, the following nine measures met or exceeded the 2019 NCQA adult Medicaid national averages:

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

In addition, the following two measures scored statistically significantly higher in 2020 than in 2018:

- *Rating of All Health Care*
- *Coordination of Care*

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

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

Of the three MQD beneficiary experience Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—KFHP QI's member experience ratings for all three MQD beneficiary experience Quality Strategy target measures 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*. KFHP QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-33 provides a summary of the key drivers identified for KFHP QI.

Table 3-33—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 it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.		✓	
Respondents reported that their personal doctor did not always spend enough time with them.			✓
Respondents reported that forms from their health plan were often not easy to fill out.	✓		N/A

N/A indicates that this question was not evaluated for this measure.

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

- Respondents reported that it was not always easy to get the care, tests, or treatment they thought they 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 their personal doctor did not always spend enough time with them.
- Respondents reported that forms from their 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 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 the need for operational improvements to support the quality of, access to, and timeliness of care and service delivery, HEDIS measure results and CAHPS results indicate a high level of performance on outcome and process measures.

KFHP QI's performance during the 2020 compliance review was below average, meeting or exceeding the statewide compliance score for five of the eight standards. KFHP QI achieved 100 percent compliance in four standards, 99 percent in the *Credentialing* standard, 91 percent in the *Program Integrity* standard, 90 percent in the *Provider Selection* standard, and 70 percent in the *Subcontracts and*

Delegation 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 (90.6 percent) of KFHP QI's measure rates ranked at or above the 50th percentile across all domains, with nearly two-thirds (65.6 percent) of the measure rates ranking above the 75th percentile. Conversely, less than 10 percent of KFHP QI's measure rates fell below the 50th percentile. KFHP QI's performance demonstrated a few areas for improvement, including the Children's Preventive Health domain. KFHP QI's measure rates met 10 of the MQD Quality Strategy targets.

KFHP QI did not score below the 50th percentile, statistically significantly lower in 2020 than in 2018, or below the 2019 NCQA adult Medicaid national average on any adult CAHPS measure, indicating strong member satisfaction. Five measures met or exceeded the 90th percentile and all three MQD beneficiary experience Quality Strategy target measures met or exceeded the 75th percentile. Based on the key drivers of member experience analysis, KFHP QI shows some opportunities for improvement in access and quality of care for members related to the ease of receiving needed care, time spent with a personal doctor, and the ease of filling out forms.

Finally, although final results for KFHP QI's PIPs were not available in 2020, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness* rapid-cycle PIPs. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services.

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 further improvement in health plan operations and implementation of managed care regulations.

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

Compliance Monitoring Review

The 2020 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-34 presents the standards and compliance scores for 'Ohana QI.

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

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	39	38	38	0	0	1	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**99**	**98**	**1**	**0**	**2**	**99%**

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

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

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

Strengths

Overall, 'Ohana QI performed above average on the compliance review, scoring 100 percent on seven of the eight standards reviewed in 2020.

Provider Selection:

'Ohana QI's participating provider agreement, QI provider manual, and network development policy confirmed that 'Ohana QI had a comprehensive process for the selection of its network providers. The provider manual demonstrated that 'Ohana QI communicated and supported network providers to advise and advocate for members regarding members' health status, medical care, treatment options, and the

right to participate in treatment decisions. ‘Ohana QI provided educational sessions in accordance with the health plan’s provider education policy that informed providers about health plan operations, managed care, claims processing, UM, and member rights and responsibilities.

Credentialing:

‘Ohana QI demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing providers that effectively evaluated providers and complied with the NCQA credentialing standards and guidelines. Through credentialing delegation agreements, pre-delegation audits, ongoing monitoring and oversight, and annual audits, ‘Ohana demonstrated that it followed the health plan’s established policy and processes for delegation of managed care functions.

Quality Assessment and Performance Improvement:

‘Ohana QI’s robust QAPI program demonstrated that the health plan effectively evaluated access, timeliness, and quality of services provided to its members. ‘Ohana QI prepared an annual QAPI program description, QAPI work plan, and QAPI evaluation of the previous year’s quality program achievements. The QAPI program description included the health plan’s organizational and accountability structure, governance, corporate and local committee and sub-committee structure, goals, and quality improvement program objectives. The QAPI work plan served as the basis for ‘Ohana QI’s annual evaluation of its QAPI program. The annual evaluation demonstrated the use of data, trending, analysis, measurement against goals, identification of accomplishments and any barriers to achieving goals, and effectiveness of actions taken in the prior year.

Health Information Systems:

‘Ohana QI demonstrated its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. ‘Ohana QI had processes in place to verify the accuracy and completeness of its claims and encounter data by conducting claims audits and running the data through various system edits within its claims and encounter data reporting systems. The health plan also had data security measures, policies, and plans related to disaster planning and recovery and business continuity.

Practice Guidelines:

‘Ohana QI had a variety of CPGs for medical conditions and for preventive care that included cardiovascular disease, asthma, epilepsy, and adolescent preventive health. The adoption of Preventive Health Guidelines was designed to detect and improve the health status of members by affording preventive care to screen for a variety of acute and potentially chronic illnesses. The health plan had processes for regular dissemination of CPG information to providers, including use of links to the website portal, provider manual, or through quarterly provider newsletters. Members were informed of how to access CPGs through information provided in the member handbook.

Program Integrity:

'Ohana QI had a compliance plan and several policies and procedures that guided the health plan's compliance program. 'Ohana QI provided initial onboarding and annual training to all employees about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security. The health plan implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. 'Ohana QI also had processes in place to report overpayments to the State.

Enrollment and Disenrollment:

'Ohana QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. As all member enrollment and disenrollment decisions were made by the State, 'Ohana QI customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. 'Ohana QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

'Ohana QI was found to be 95 percent compliant with the Subcontracts and Delegation standard, with one element scoring a *Partially Met.* The health plan had several executed subcontracts for various health plan administrative functions. 'Ohana QI had policies and procedures for monitoring, oversight, and evaluation of its delegated entities. A review of the subcontracts revealed that the medical record retention requirements were inconsistent with the State's retention policy of 10 years. The corrective action required by 'Ohana QI was to amend the subcontracts to include a provision that the subcontractor must retain medical records in compliance with the State's health plan contract (10 years).

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 seven standard and two nonstandard supplemental data sources for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2020 measure reporting. All convenience samples passed HSAG's review.

The auditors did not have any recommendations for 'Ohana QI.

All QI measures that 'Ohana QI was required to report received the audit result of *Reportable*, where a reportable rate was submitted. For 'Ohana QI reporting, the *Follow-Up Care for Children Prescribed ADHD Medication* 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—*Prenatal and Postpartum Care—Postpartum Care*
- Group B: Anticipatory Guidance & Counseling—*Adolescent Well-Care Visits*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 3*
- Group F: Exclusions—All Medical Record Exclusions

Access and Risk-Adjusted Utilization Performance Measure Results

'Ohana QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-35. All four measure rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure fell below the 50th percentile, with three of four measure rates falling below the 25th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Hospitalization for Potentially Preventable Complications*; therefore, no prior years' rates or comparisons to national benchmarks are presented. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2020.

Table 3-35—'Ohana QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	59.44%	60.55%	1.87%	★
45–64 Years	79.25%	79.71%	0.58%	★
65 Years and Older	88.81%	88.02%	-0.89%	★★
Total	72.97%	73.60%	0.86%	★
Hospitalization for Potentially Preventable Complications				
Acute ACSC—Observed Discharges—Total	—	11.12	—	NC
Acute ACSC—O/E Ratio—Total	—	0.53	—	NC
Chronic ACSC—Observed Discharges—Total	—	21.16	—	NC
Chronic ACSC—O/E Ratio—Total	—	0.93	—	NC
Total ACSC—Observed Discharges—Total	—	32.27	—	NC
Total ACSC—O/E Ratio—Total	—	0.83	—	NC

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Plan All-Cause Readmissions[1]				
*Index Total Stays—Observed Readmissions—Total**	—	10.53%	—	NC
*Index Total Stays—O/E Ratio—Total**	—	0.96	—	NC

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends a break in trending between HEDIS 2020 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile or above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Children's Preventive Health Performance Measure Results

'Ohana QI's Children's Preventive Health performance measure results are shown in Table 3-36. Five rates in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2020. One measure exceeded the 90th percentile. Conversely, 16 measure rates fell below the 50th percentile, with 14 measure rates falling below the 25th percentile. There was one measure in this domain with an MQD Quality Strategy target for HEDIS 2020 (i.e., *Childhood Immunization Status—Combination 3*), and 'Ohana QI did not reach the established target, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.15%	49.15%	0.00%	★★
Childhood Immunization Status				
Combination 3	50.16%	56.43%	12.50%	★
DTaP	58.26%	62.38%	7.07%	★
Hepatitis B	73.83%	73.35%	-0.65%	★
HiB	78.19%	74.92%	-4.18%	★
IPV	74.14%	74.92%	1.05%	★
MMR	77.57%	74.92%	-3.42%	★
Pneumococcal Conjugate	58.26%	60.50%	3.84%	★
VZV	74.77%	72.73%	-2.73%	★

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	48.28%	51.22%	6.09%	★
Combination 2 (Meningococcal, Tdap, HPV)	18.62%	23.17%	24.44%	★
HPV	22.07%	26.83%	21.57%	★
Meningococcal	53.10%	54.88%	3.35%	★
Tdap	52.76%	56.91%	7.87%	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	3.88%	2.38%	-38.66%	★★
Six or More Well-Child Visits	67.31%	74.49%	10.67%	★★★★★
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	62.23%	63.66%	2.30%	★

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.*
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Women's Health Performance Measure Results

'Ohana QI's Women's Health performance measure results are shown in Table 3-37. Two measure rates that could be compared to national benchmarks fell below the 25th percentile. Three measures[3-24] in this domain had an MQD Quality Strategy target for HEDIS 2020. None of 'Ohana QI's measure rates met or exceeded the established MQD Quality Strategy targets.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	51.35%	50.82%	-1.03%	★
Cervical Cancer Screening[2]				
Cervical Cancer Screening	45.26%	45.74%	1.06%	★
Prenatal and Postpartum Care[1]				

[3-24] Due to technical specification changes for HEDIS 2020, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Prenatal and Postpartum Care* measure.

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Timeliness of Prenatal Care	—	86.92%	—	NC
Postpartum Care	—	67.03%	—	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 2020, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.
[2] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Care for Chronic Conditions Performance Measure Results

'Ohana QI's Care for Chronic Conditions performance measure results are shown in Table 3-38. The *Comprehensive Diabetes Care* measure rates were rotated as a result of COVID-19 public health emergency; therefore, there is no relative difference in rates between HEDIS 2019 and HEDIS 2020. Three measure rates ranked at or above the 50th percentile. Conversely, three measure rates fell below the 50th percentile. CY 2019 represented the first year for reporting the non-HEDIS measures *COPD or Asthma in Older Adults Admission Rate* and *Heart Failure Admission Rate*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Five measures[3-25] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, and 'Ohana QI met the target for two of these measures: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Eye Exam (Retinal) Performed*.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	88.08%	88.08%	0.00%	★★
*HbA1c Poor Control (>9.0%)**	39.66%	39.66%	0.00%	★★
HbA1c Control (<8.0%)	51.58%	51.58%	0.00%	★★★
Eye Exam (Retinal) Performed	65.45%	65.45%	0.00%	★★★★

[3-25] Within this domain, there were five 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)*.

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Medical Attention for Nephropathy	91.48%	91.48%	0.00%	★★★
Blood Pressure Control (<140/90 mm Hg)	63.02%	63.02%	0.00%	★★
COPD or Asthma in Older Adults Admission Rate				
40–64 Years	—	63.14	—	NC
65 Years and Older	—	114.39	—	NC
Total	—	78.25	—	NC
Heart Failure Admission Rate				
18–64 Years	—	65.85	—	NC
65 Years and Older	—	170.51	—	NC
Total	—	84.80	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** For this indicator, a lower rate indicates better performance.*
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 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 3-39. Two measure rates that were compared to national benchmarks fell below the 50th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Screening, Brief Intervention, and Referral to Treatment*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Two measures[3-26] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, and 'Ohana QI did not reach the established targets, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	33.83%	33.19%	-1.89%	★★
30-Day Follow-Up—Total	48.76%	53.28%	9.27%	★★

[3-26] 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 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	—	NC
Continuation and Maintenance Phase	NA	NA	—	NC
Screening, Brief Intervention, and Referral to Treatment				
SBIRT Training Plan Submitted to DHS/MQD	—	Met	—	NC
SBIRT Training Plan Recommendations from DHS/MQD Addressed	—	Met	—	NC
ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	—	Met	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
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.
Met indicates the health plan met the data element criteria.
— 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Conclusions and Recommendations

Based on HSAG's analyses of 'Ohana QI's 31 measure rates comparable to benchmarks, only four measure rates (12.9 percent) ranked at or above the 50th percentile with two measure rates (6.5 percent) ranking above the 75th percentile, indicting positive performance in well-child visits for infants and eye care for members with diabetes. Additionally, 'Ohana QI met two of the MQD Quality Strategy targets for HEDIS 2020: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Eye Exam (Retinal) Performed*.

Conversely, 27 measure rates comparable to benchmarks (87.1 percent) ranked below the 50th percentile, with 19 measure rates (61.3 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 and Risk-Adjusted Utilization
  - *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *45–64 Years*, and *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 Third, Fourth, Fifth, and Sixth Years of Life*
- Women's Health
  - *Breast Cancer Screening*
  - *Cervical Cancer Screening*

Validation of Performance Improvement Projects

For validation year 2020, 'Ohana QI submitted two state-mandated PIPs for validation—*Improving Rates for Adolescent Well-Child Visits* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge*. These rapid-cycle PIPs were implemented in July 2019. The PIP topics represent key areas of focus for improvement and are part of the MQD Quality Strategy.

Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. The focus of the *Improving Rates for Adolescent Well-Child Visits* PIP is to increase the percentage of adolescent well-care visits among 12 to 21-year-olds in the selected narrowed focus panel of providers. The focus of the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP is to increase the percentage of compliance for seven-day follow-up visits after hospitalization for mental illness or intentional self-harm among members 6 years and older.

Findings

'Ohana QI successfully achieved all validation criteria in Modules 1 through 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2020 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2021 annual validation.

For each PIP topic, in Module 1, 'Ohana QI determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global Aim and SMART Aim, and developed the key driver diagram. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. In Module 2, 'Ohana QI defined how and when it will be evident that improvement is being achieved.

Table 3-40 outlines 'Ohana QI's SMART Aim for each PIP.

Table 3-40—PIP Topic and SMART Aim Statements for 'Ohana QI

PIP Topic	SMART Aim Statement
Improving Rates for Adolescent Well-Child Visits	By 1/31/2021, 'Ohana Health Plan aims to increase the percentage of adolescent well-care visits in the panel of providers (Bay Clinic, Kalihi Palama Health Center, Dr. Sorbella Guillermo, Dr. Vincent Ramo, and Koolauloa Community Health and Wellness) from 44.66% to 49.66%.
Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge	By 1/31/2021, increase the percentage of the follow-up post-hospitalization within seven days of discharge for members (age 6 and older) who discharge from Adventist Health Castle, The Queens Medical Center, Kahi Mohala Hospital, Hilo Medical Center, and Maui Memorial Hospital, from 28.82% to 40.00%.

In Module 3, for each PIP, 'Ohana QI completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 3-41 and Table 3-42 summarize the potential interventions 'Ohana QI identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 3-41—Intervention Determination Summary for the *Improving Rates for Adolescent Well-Child Visits* PIP for 'Ohana QI

Failure Modes	Potential Interventions
Adolescent/parent/guardian cannot be reached by provider or health plan for assistance with scheduling an appointment.	Explore claims to see if members have any claims for providers not assigned to them. Reach out to those providers to see if the health plan can obtain the correct demographic information to contact members. Research other systems (e.g., Hawaii Health Information Exchange—Health eNet) to locate updated member demographic information.
Adolescent member and/or parents/guardians do not think they need a well-child visit and immunizations.	Patient care advocates (PCAs) and/or care gap coordinators (CGCs) emphasizing and educating on the importance of a well visit to members and their parents/guardians over the phone. Incentives for members (gift cards) to keep scheduled well-child visits (healthy rewards 2020).
Adolescent goes in for a sick visit, birth control, or a sport physical and not for a well-child visit.	Educating providers, members, and parents/guardians to do a well-child visit at the same time as a sick visit, OB/GYN visit, or physical.

The health plan chose to test the "Emphasizing and educating more on the importance of a well-child visit to members and their parents/guardians through telephone outreach, by Patient Care Advocates (PCAs) and/or Care Gap Coordinators (CGCs), while incentivizing members with gift cards ($25) to keep scheduled well-child visits (Healthy Rewards 2020) when scheduling/reminding members on their well child visit" intervention. Based on the intervention plan, the initial testing start date for this intervention was in February2020; however, due to the COVID-19 pandemic, the intervention testing was delayed until July 2020. The health plan is continuing to test this intervention. The final intervention

testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Table 3-42—Intervention Determination Summary for the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP for 'Ohana QI

Failure Modes	Potential Interventions
Member does not have an adequate discharge plan before inpatient discharge.	Identify qualified BH provider who can focus on all the health plan members to briefly follow up with them post-discharge within 7 days. Conduct a short-term case management service to identify member needs the health plan can assist with such as housing, food assistance, etc.
CGC adds all members admitted for mental illness to the tracker but is unaware that the treating diagnosis could change during the course of the treatment.	Educate CGCs on the facility process and review the specifications of the measure to have them identify only the members who had a primary diagnosis of mental illness. Track the correct members for timely follow-up to be completed, within 7 days post-hospital discharge. Add the members to the tracker for follow-up. The CGC will mark the encounters with diagnoses that changed through the course of the treatment as changed diagnoses at discharge.
CGC does not see the importance of the process being completed in a timely manner.	Educate CGCs on the importance of completing member outreach soon after discharge to assure a timely follow-up appointment is scheduled. Add the process in the tracker to assure the CGC conducts timely member outreach and monitors the process.

The health plan chose to test the "'Ohana health plan will identify a qualified behavioral health provider who can provide a short-term case management service to conduct a follow-up visit with member within seven (7) days post inpatient discharge" intervention. The health plan began testing this intervention in January 2020. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Strengths and Weaknesses

'Ohana QI designed a methodologically sound project for both PIPs and was successful in building quality improvement teams and establishing collaborative partnerships. The health plan also successfully completed Module 3 and identified opportunities for improvement and potential interventions to address the identified flaws or gaps.

Recommendations for Improvement

Based on the 2020 PIP validation, HSAG recommends the following:

- 'Ohana QI should ensure that each intervention selected for testing is a change to the current process, will address identified flaws or gaps, and is expected to have a positive impact on the SMART Aim measure.

- When planning a test of change, ‘Ohana QI should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- ‘Ohana QI should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out when designing the intervention testing plan.
- To ensure a methodologically sound intervention testing methodology, ‘Ohana QI should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- The health plan should document COVID-19 pandemic-related challenges in Module 4 and Module 5 submissions, and clearly indicate if any modifications were made to the interventions based on those challenges.
- ‘Ohana QI should continue testing interventions for the PIP through the SMART Aim end date of January 31, 2021. ‘Ohana QI should reach out to HSAG with any questions it has during this time.

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

The following is a summary of the adult CAHPS performance highlights for ‘Ohana QI.

Findings

Table 3-43 presents the 2020 percentage of top-box responses for ‘Ohana QI compared to the 2019 NCQA adult Medicaid national averages and the corresponding 2018 scores.[3-27,3-28] Additionally, the overall member experience ratings (i.e., star ratings) resulting from ‘Ohana QI’s top-box scores compared to NCQA’s 2019 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-29]

Table 3-43—Adult Medicaid CAHPS Results for ‘Ohana QI

Measure	2018 Scores	2020 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	56.8%	62.5%	★★★

[3-27] The adult population was not surveyed in 2019; therefore, the 2020 CAHPS scores could not be compared to the corresponding 2019 scores.

[3-28] National Committee for Quality Assurance. *HEDIS® 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2019.

[3-29] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

Measure	2018 Scores	2020 Scores	Star Ratings
Rating of All Health Care	54.3%	55.3%	★★★
Rating of Personal Doctor	66.8%	68.7%	★★★
Rating of Specialist Seen Most Often	71.1%	68.9%	★★★
Composite Measures			
Getting Needed Care	83.9%	82.0%	★★
Getting Care Quickly	81.8%	82.7%	★★★
How Well Doctors Communicate	92.2%	92.4%	★★★
Customer Service	87.1%	87.0%	★
Individual Item Measure			
Coordination of Care	80.3%	87.4%	★★★★

Cells highlighted in yellow represent scores that are at or above the 2019 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2019 NCQA adult Medicaid national averages.
▲ Indicates the 2020 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2020 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

Strengths

For ‘Ohana QI’s adult Medicaid population, the following seven measures met or exceeded the 2019 NCQA adult Medicaid national averages:

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

None of the three MQD beneficiary experience 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*. 'Ohana QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-44 provides a summary of the key drivers identified for 'Ohana QI.

Table 3-44—'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 it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.		✓	
Respondents reported that it was often not easy for them to obtain appointments with specialists.		✓	N/A
Respondents reported that their health plan's customer service did not always give them the information or help they needed.	✓		N/A
Respondents reported that forms from their health plan were often not easy to fill out.	✓		N/A
N/A indicates that this question was not evaluated for this measure.			

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 it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.
- Respondents reported that it was often not easy for them 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 health plan's customer service did not always give them the information or help they needed.
- Respondents reported that forms from their health plan were often not easy to fill out.

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, performance on outcome and process measures showed considerable room for improvement.

'Ohana QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. 'Ohana QI's performance during the 2020 compliance review was above average, meeting or exceeding the statewide compliance score for all eight standards. 'Ohana QI achieved 100 percent compliance in seven standards and 95 percent in the *Subcontracts and Delegation* standard. '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.

While policies, procedures, and staff were in place to monitor performance and promote quality, access, and timeliness of care, health plan performance indicators and member satisfaction scores were generally below the national Medicaid 50th percentile.

Overall, more than three-quarters (87.1 percent) of 'Ohana QI's measures fell below the 50th percentile across all domains, with over half (61.3 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS 2019, '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 and Risk-Adjusted Utilization, Children's Preventive Health, and Women's Health domains. Overall, only two of the MQD Quality Strategy targets were met in HEDIS 2020.

Similarly, 'Ohana QI's CAHPS results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower in 2020 than in 2018, the following two measures were below the 50th percentile: *Getting Needed Care* and *Customer Service*. Additionally, two of the nine measures scored below the 2019 NCQA adult Medicaid national averages: *Getting Needed Care* and *Customer Service*.

Finally, although final results for 'Ohana QI's PIPs were not available in 2020, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Improving Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* rapid-cycle PIPs. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

Compliance Monitoring Review

The 2020 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-45 presents the standards and compliance scores for UHC CP QI.

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

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	10	0	0	0	100%
III	Credentialing	39	37	37	0	0	2	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	9	2	0	0	91%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**96**	**2**	**0**	**3**	**99%**

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

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

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

Strengths

Overall, UHC CP QI performed above average on the compliance review, scoring 100 percent on seven of the eight standards reviewed in 2020.

Provider Selection:

UHC CP QI's policies and procedures, provider agreement appendix template, and care provider manual confirmed that the health plan had a comprehensive process for the selection of its network providers. UHC CP QI demonstrated that it communicated and supported network providers to advise and advocate for members regarding members' health status, medical care, treatment options, and the right to

participate in treatment decisions. UHC CP QI's large-scale training and provider Town Hall presentations were comprehensive and informed providers about health plan operations, managed care, claims, and UM.

Subcontracts and Delegation:

UHC CP QI had several executed subcontracts for various health plan administrative functions. The subcontracts included all required federal and State contract provisions. UHC CP QI provided evidence of having conducted annual audits of its delegates and subcontractors reviewed under this standard. For those delegates, UHC CP QI provided evidence of ongoing monitoring, which included regular review of reports from subcontractors. UHC CP QI routinely conducted interrater reliability (IRR) reviews on health and functional assessments and level-of-care assessments completed by the Community Case Management Agencies (CCMAs) to ensure consistency, accuracy, and timeliness of the assessments.

Credentialing:

UHC CP QI demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing providers that effectively evaluated providers and complied with the NCQA credentialing standards and guidelines. UHC CP QI monitored its credentialing delegates by regularly reviewing reports, compiling quarterly scorecards, performing file audits, and conducting an annual assessment.

Quality Assessment and Performance Improvement:

Along with UHC CP QI's local, Hawaii-based staff members responsible for the QAPI program and activities, additional support, leadership, and consultation from its national headquarters (i.e., the UnitedHealthcare Health Plan Quality Management Committee [QMC] and the National Quality Oversight Committee [NQOC]) were provided. The health plan's comprehensive quality improvement program description included its QAPI program organizational structure; roles and responsibilities of individuals; as well as national and regional supports, governance, and committee structure at all levels (i.e., local/Hawaii, regional, and national). UHC CP QI's QAPI program activities encompassed quality of care, patient safety, and quality of service. The annual QAPI program work plan described improvement activities that included major objectives, identification of responsible individuals or groups, and time frames for completion. The work plan also functioned as the basis for the health plan's annual evaluation of its QAPI program.

Health Information Systems:

UHC CP QI had Hawaii-based IS staff members and national corporate support for the management of all operations related to the development and maintenance of its health information systems. The health plan demonstrated its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. UHC CP QI also had processes in place to verify the accuracy and completeness of its claims and encounter data by examining and comparing monthly paid claims volume by product line, conducting claims audits, and running the data through various system edits within its claims systems. UHC CP QI

had data security measures and corporate-level (i.e., UnitedHealthcare Group [UHG]) policies and plans related to disaster planning and recovery and business continuity, as well as local-level procedures depicting Hawaii leadership roles and responsibilities in the event of a disaster.

Practice Guidelines:

The UHG national committee structure was primarily responsible for the development, review, and approval of CPG topics. Selection and review by three UHG national committees (i.e., Medical Technology Assessment Committee, National Medical Care Management Committee, and NQOC) ensured that only nationally recognized guidelines or consensus documents were adopted. To meet the healthcare needs of UHC CP QI members, UHC CP participated in the national process and determined the relevance of CPGs for its populations and conditions. UHC CP QI's CPGs were disseminated to providers online via links to UHC CP's provider website and providers were also notified of CPGs through newsletters and other mailings. Dissemination of CPGs to members occurred through member services. Further, members were informed in the member handbook of their right to request CPG information.

Enrollment and Disenrollment:

UHC CP QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. As all member enrollment and disenrollment decisions were made by the State, UHC CP QI customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. UHC CP did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State using the DHS 1179 form when it became aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

UHC CP QI was found to be 91 percent compliant with the Program Integrity standard, with two elements scoring a *Partially Met*. UHC CP QI had a compliance plan and several policies and procedures that guided the health plan's compliance program. UHC CP QI had processes in place to report overpayments due to FWA promptly using the State's reporting templates. While UHC CP QI could speak to a general process for reconciling capitation payments from the State against eligibility files, it did not have any written policy, procedure, or process in place to report to the State, or require subcontractors to report to the State, within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract. UHC CP QI's required corrective actions were to develop and implement a written policy, procedure, and/or process to report capitation overpayments to the State and to update its compliance plan to be consistent with current reporting structures and Board of Directors' involvement.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated UHC CP QI's IS capabilities for accurate HEDIS reporting. UHC CP QI was found to be *Fully Compliant* with all IS assessment standards. This demonstrated that UHC CP QI generally had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. UHC CP QI elected to use four standard and five nonstandard supplemental data sources for its performance measure reporting. No concerns were identified, and these data sources were approved for HEDIS 2020 measure reporting. All convenience samples passed HSAG's review.

The auditors did not have any recommendations for UHC CP QI.

All QI measures that 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 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—*Prenatal and Postpartum Care—Postpartum Care*
- Group B: Anticipatory Guidance & Counseling—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 3*
- Group F: Exclusions—All Medical Record Exclusions

Access and Risk-Adjusted Utilization Performance Measure Results

UHC CP QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-46. Three of four measure rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure fell below the 50th percentile and one measure rate exceeded the 75th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Hospitalization for Potentially Preventable Complications*; therefore, no prior years' rates or comparisons to national benchmarks are presented. There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2020.

Table 3-46—UHC CP QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	57.74%	58.05%	0.54%	★
45–64 Years	79.23%	78.72%	-0.64%	★
65 Years and Older	94.79%	94.01%	-0.82%	★★★★
Total	76.62%	76.85%	0.30%	★★
Hospitalization for Potentially Preventable Complications				
Acute ACSC—Observed Discharges—Total	—	13.93	—	NC
Acute ACSC—O/E Ratio—Total	—	0.79	—	NC
Chronic ACSC—Observed Discharges—Total	—	20.15	—	NC
Chronic ACSC—O/E Ratio—Total	—	1.11	—	NC
Total ACSC—Observed Discharges—Total	—	33.75	—	NC
Total ACSC—O/E Ratio—Total	—	1.06	—	NC
Plan All-Cause Readmissions[1]				
*Index Total Stays—Observed Readmissions—Total**	—	10.37%	—	NC
*Index Total Stays—O/E Ratio—Total**	—	0.93	—	NC

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends a break in trending between HEDIS 2020 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Children's Preventive Health Performance Measure Results

UHC CP QI's Children's Preventive Health performance measure results are shown in Table 3-47. The *Childhood Immunization Status*; *Immunizations for Adolescents*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure rates were rotated as a result of the COVID-19 public health emergency; therefore, there is no relative difference in rates between HEDIS 2019 and HEDIS 2020. Of the measures that were not rotated, one measure rate exceeded the 90th percentile. Conversely, 16 measure rates fell below the 50th percentile and 15 of these measure rates fell below the 25th percentile. One measure in this domain had an MQD Quality Strategy target for HEDIS 2020 (i.e.,

Childhood Immunization Status—Combination 3), and UHC CP QI did not reach the established target, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	44.28%	46.96%	6.05%	★★
Childhood Immunization Status				
Combination 3	63.07%	63.07%	0.00%	★
DTaP	68.09%	68.09%	0.00%	★
Hepatitis B	81.16%	81.16%	0.00%	★
HiB	80.40%	80.40%	0.00%	★
IPV	80.40%	80.40%	0.00%	★
MMR	81.91%	81.91%	0.00%	★
Pneumococcal Conjugate	68.09%	68.09%	0.00%	★
VZV	80.90%	80.90%	0.00%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	54.60%	54.60%	0.00%	★
Combination 2 (Meningococcal, Tdap, HPV)	26.07%	26.07%	0.00%	★
HPV	29.14%	29.14%	0.00%	★
Meningococcal	59.20%	59.20%	0.00%	★
Tdap	59.20%	59.20%	0.00%	★
Well-Child Visits in the First 15 Months of Life				
*No Well-Child Visits**	1.44%	3.01%	109.03%	★
Six or More Well-Child Visits	72.70%	76.19%	4.80%	★★★★★
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	61.99%	61.99%	0.00%	★

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.*
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Women's Health Performance Measure Results

UHC CP QI's Women's Health performance measure results are shown in Table 3-48. One measure rate in this domain demonstrated a relative improvement of more than 10 percent in HEDIS 2020. Of the two

measure rates that could be compared to national benchmarks, one measure rate fell below the 25th percentile and one measure rate met or exceeded the 50th percentile. Three measures[3-30] in this domain had an MQD Quality Strategy target for HEDIS 2020. None of UHC CP QI's measure rates met or exceeded the established MQD Quality Strategy targets.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Breast Cancer Screening				
Breast Cancer Screening	60.57%	60.54%	-0.05%	★★★
Cervical Cancer Screening[2]				
Cervical Cancer Screening	48.18%	53.53%	11.10%	★
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	—	91.48%	—	NC
Postpartum Care	—	78.83%	—	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 2020, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, prior years' rates are not displayed and comparisons to benchmarks are not performed for this measure.
[2] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Care for Chronic Conditions Performance Measure Results

UHC CP QI's Care for Chronic Conditions performance measure results are shown in Table 3-49. Six measure rates that could be compared to national benchmarks ranked at or above the 50th percentile, with two measure rates exceeding the 75th percentile and two measure rates exceeding the 90th percentile. CY 2019 represented the first year for reporting the non-HEDIS measures *COPD or Asthma in Older Adults Admission Rate* and *Heart Failure Admission Rate*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Five measures[3-31] within this domain were associated with an MQD Quality Strategy target for HEDIS 2020, and UHC CP QI met the target for

[3-30] Due to technical specification changes for HEDIS 2020, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Prenatal and Postpartum Care* measure.
[3-31] Within this domain, there were five 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)*.

three of these measures: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed*.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing	88.81%	89.54%	0.82%	★★★
*HbA1c Poor Control (>9.0%)**	29.93%	29.20%	-2.44%	★★★★
HbA1c Control (<8.0%)	56.93%	60.10%	5.57%	★★★★
Eye Exam (Retinal) Performed	67.88%	70.56%	3.95%	★★★★★
Medical Attention for Nephropathy	90.75%	94.89%	4.56%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	65.69%	67.40%	2.60%	★★★
COPD or Asthma in Older Adults Admission Rate				
40–64 Years	—	31.84	—	NC
65 Years and Older	—	64.82	—	NC
Total	—	46.68	—	NC
Heart Failure Admission Rate				
18–64 Years	—	68.80	—	NC
65 Years and Older	—	135.30	—	NC
Total	—	88.28	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** For this indicator, a lower rate indicates better performance.*
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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Behavioral Health Performance Measure Results

UHC CP QI's Behavioral Health performance measure results are shown in Table 3-50. Two rates in this domain demonstrated a relative decline of more than 15 percent in HEDIS 2020. Further, these two measure rates fell below the 50th percentile. CY 2019 represented the first year for reporting the non-HEDIS measure *Screening, Brief Intervention, and Referral to Treatment*; therefore, no prior years' rates or comparisons to national benchmarks are presented. Two measures[3-32] within this domain were

[3-32] 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*.

associated with an MQD Quality Strategy target for HEDIS 2020, and UHC CP QI did not reach the established targets, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	39.37%	32.43%	-17.63%	★★
30-Day Follow-Up—Total	61.32%	47.45%	-22.62%	★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	—	NC
Continuation and Maintenance Phase	NA	NA	—	NC
Screening, Brief Intervention, and Referral to Treatment				
SBIRT Training Plan Submitted to DHS/MQD	—	Met	—	NC
SBIRT Training Plan Recommendations from DHS/MQD Addressed	—	Met	—	NC
ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	—	Met	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
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.
Met indicates the health plan met the data element criteria.
— 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Conclusions and Recommendations

Based on HSAG's analyses of UHC CP QI's 31 measure rates comparable to benchmarks, a total of nine measure rates (29.0 percent) ranked at or above the 50th percentile, with three of these rates (9.7 percent) ranking above the 75th percentile and three of these rates (9.7 percent) exceeding the 90th percentile, indicating positive performance in several areas, including access to care for elderly members, well-child visits for infants, and care for members with diabetes. Additionally, UHC CP QI met three of the MQD Quality Strategy targets for HEDIS 2020: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed.*

Conversely, 22 of UHC CP QI's measure rates comparable to benchmarks (71.0 percent) fell below the 50th percentile, with 19 of these rates (61.3 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 and Risk-Adjusted Utilization
  - *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* and *45–64 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)*, *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
  - *Cervical Cancer Screening*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

Validation of Performance Improvement Projects

For validation year 2020, UHC CP QI submitted two state-mandated PIPs for validation—*Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center* and *Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64*. These rapid-cycle PIPs were implemented in July 2019. The PIP topics represent key areas of focus for improvement and are part of the MQD Quality Strategy.

Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. The focus of the *Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center* PIP is to increase the percentage of adolescent well-care visits completed among members assigned to Waianae Coast Comprehensive Health Center. The focus of the *Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64* PIP is to increase the percentage of compliance for seven-day follow-up visits after hospitalization for mental illness or intentional self-harm among members 18 to 64 years of age.

Findings

UHC CP QI successfully achieved all validation criteria in Modules 1 through 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2020 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions,

including SMART Aim measure outcomes and intervention testing results, for the 2021 annual validation.

For each PIP topic, in Module 1, UHC CP QI determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global Aim and SMART Aim, and developed the key driver diagram. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. In Module 2, UHC CP QI defined how and when it will be evident that improvement is being achieved.

Table 3-51 outlines UHC CP QI's SMART Aim for each PIP.

Table 3-51—PIP Topic and SMART Aim Statements for UHC CP QI

PIP Topic	SMART Aim Statement
Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center	By January 31, 2021, increase the percentage of adolescent well-care (AWC) visits completed among members assigned to Waianae Coast Comprehensive Health Center as their primary care physician (PCP), from 26.94% to 29.94%.
Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64	By January 31, 2021, increase the rate of follow-up visits with a mental health practitioner within seven days after acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm for non-dual QUEST Integration members ages 18 to 64, from 34.90% to 40.29%.

In Module 3, for each PIP, UHC CP QI completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 3-52 and Table 3-53 summarize the potential interventions UHC CP QI identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 3-52—Intervention Determination Summary for the *Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center* PIP for UHC CP QI

Failure Modes	Potential Interventions
Member/guardian does not initiate contact with Waianae Coast Comprehensive Health Center (WCCHC) to establish care.	UHC CP Member Services conducts telephonic outreach to members/guardians assigned to WCCHC who have not established care and are due for an AWC visit. Assist as needed and schedule a visit or update the member's PCP if care has been established elsewhere.
Member/guardian is unaware of the member's assignment to WCCHC.	UHC CP Member Services conducts telephonic outreach to members/guardians auto-assigned to WCCHC who have not established care and are due for an AWC visit. Inform auto-assigned PCP and assist as needed to schedule a visit with WCCHC or update the member's PCP if care has been established elsewhere.

Failure Modes	Potential Interventions
Member/guardian's contact information is not current.	Collaborate with WCCHC and schools (if member is school-aged) on the data exchange process for member contact information. With updated contact information, UHC CP Member Services conducts outreach to members/guardians due for an AWC visit to assist as needed/schedule a visit.
Member/guardian does not feel the need to see WCCHC unless sick.	Develop and implement educational materials targeted toward adolescents about the importance of preventive care. Leverage social media to deliver message.
Member/guardian does not have transportation to the visit.	Collaborate with a community-based organization, like Hawaii Keiki, to expand reach of school-based clinics where members can complete AWC visits.

The health plan chose to test the "AWC Call Outreach Campaign to WCCHC Auto-Assigned and Unestablished Members" intervention. The intervention was initiated in April 2020. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Table 3-53—Intervention Determination Summary for the *Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64* PIP for UHC CP QI

Failure Modes	Potential Interventions
Member lacks motivation to attend a follow-up appointment within seven days after discharge.	Modify the existing workflow to increase behavioral health field care advocate (BH FCA) face-to-face (FTF) visits with the member while still inpatient to increase trust. Educate on the importance of follow-up. Incorporate member incentives (e.g., food, gift card).
Member is a no-show at the scheduled FTF follow-up visit with the BH FCA after discharge.	Modify the existing workflow to increase BH FCA FTF visits with the member while still inpatient to increase trust. Educate on the importance of follow-up. Incorporate member incentives (e.g., food, gift card).
Member is unfamiliar with or lacks trust in the mental health practitioner (MHP).	If scheduling with previously seen MHPs is not possible, use BH FCA FTF visits to educate the member on the MHP and set up an introductory call between the member and MHP.
The follow-up appointment was scheduled with limited notice to the MHP.	Incentivize MHPs to see members within seven days after discharge.
There is a shortage of MHPs, especially with prescribing authority (i.e., psychiatrists).	Incentivize MHPs with prescribing authority to see members within seven days after discharge.

The health plan chose to test the "Provider incentive for completion of 7-day FUH visits" intervention. This intervention was initiated in April 2020. In September 2020, the health plan initiated a second intervention, "7-Day FUH Telehealth Pilot," wherein the health plan is testing a telehealth program in which two licensed clinical social workers (LCSWs) reserve one hour every weekday morning for

seven-day FUH appointments via telehealth. The final intervention testing results for the interventions and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Strengths and Weaknesses

UHC CP QI designed a methodologically sound project for both PIPs and was successful in building quality improvement teams and establishing collaborative partnerships. The health plan also successfully completed Module 3 and identified opportunities for improvement and potential interventions to address the identified flaws or gaps.

Recommendations for Improvement

Based on the 2020 PIP validation, HSAG recommends the following:

- UHC CP QI should ensure that each intervention selected for testing is a change to the current process, will address identified flaws or gaps, and is expected to have a positive impact on the SMART Aim measure.
- When planning a test of change, UHC CP QI should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- UHC CP QI should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out when designing the intervention testing plan.
- To ensure a methodologically sound intervention testing methodology, UHC CP QI should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- The health plan should document COVID-19 pandemic-related challenges in Module 4 and Module 5 submissions, and clearly indicate if any modifications were made to the interventions based on those challenges.
- UHC CP QI should continue testing interventions for the PIP through the SMART Aim end date of January 31, 2021. UHC CP QI should reach out to HSAG with any questions it has during this time.

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

The following is a summary of the adult CAHPS performance highlights for UHC CP QI.

Findings

Table 3-54 presents the 2020 percentage of top-box responses for UHC CP QI compared to the 2019 NCQA adult Medicaid national averages and the corresponding 2018 scores.[3-33,3-34] Additionally, the overall member experience ratings (i.e., star ratings) resulting from UHC CP QI's top-box scores compared to NCQA's 2019 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-35]

Table 3-54—Adult Medicaid CAHPS Results for UHC CP QI

Measure	2018 Scores	2020 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	63.0%	66.1%	★★★★
Rating of All Health Care	55.0%	57.3%	★★★
Rating of Personal Doctor	66.2%	71.3%	★★★★
Rating of Specialist Seen Most Often	66.8%	69.2%	★★★
Composite Measures			
Getting Needed Care	83.1%	79.6%	★
Getting Care Quickly	85.2%	77.8% ▼	★
How Well Doctors Communicate	93.2%	94.5%	★★★★
Customer Service	88.0%	88.8%	★★
Individual Item Measure			
Coordination of Care	82.3%	89.3% ▲	★★★★★

Cells highlighted in yellow represent scores that are at or above the 2019 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2019 NCQA adult Medicaid national averages.
▲ Indicates the 2020 score is statistically significantly higher than the 2018 score.
▼ Indicates the 2020 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

3-33 The adult population was not surveyed in 2019; therefore, the 2020 CAHPS scores could not be compared to the corresponding 2019 scores.
3-34 National Committee for Quality Assurance. *HEDIS® 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2019.
3-35 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

Strengths

For UHC CP QI's adult Medicaid population, the following seven measures met or exceeded the 2019 NCQA adult 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*
- *Customer Service*
- *Coordination of Care*

In addition, one measure scored statistically significantly higher in 2020 than in 2018 and met or exceeded the 90th percentile, *Coordination of Care*.

Of the three MQD beneficiary experience Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—UHC CP QI's member experience ratings for *Rating of Health Plan* and *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*. UHC CP QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-55 provides a summary of the key drivers identified for UHC CP QI.

Table 3-55—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 they 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 they needed through their health plan.	✓	✓	
Respondents reported that their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.			✓

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Respondents reported that their health plan's customer service did not always give them the information or help they needed.	✓		N/A
N/A indicates that this question was not evaluated for this measure.			

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 they 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 they 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 their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.
- Respondents reported that their health plan's customer service did not always give them the information or help they needed.

Overall Assessment of Quality, Access, and Timeliness of Care

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

Conclusions

In general, UHC CP QI's performance results illustrate 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, performance on outcome and process measures showed considerable room for improvement.

UHC CP QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. UHC CP QI's performance during the 2020 compliance review was above average, meeting or exceeding the statewide compliance score for seven of the eight standards. UHC CP QI achieved 100 percent compliance in seven standards and 91 percent in the *Program Integrity* standard. 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.

While policies, procedures, and staff were in place to monitor performance and promote quality, access, and timeliness of care, health plan performance indicators and member satisfaction scores were generally below the national Medicaid 50th percentile.

Overall, nearly three-quarters (71.0 percent) of UHC CP QI's measure rates fell below the 50th percentile, with 61.3 percent of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS 2019, 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 and Risk-Adjusted Utilization, Children's Preventive Health, Women's Health, and Behavioral Health domains. Overall, only three of the MQD Quality Strategy targets were met in HEDIS 2020.

Similarly, UHC CP QI's CAHPS results illustrate opportunities for improvement in members' experience. The following three measures were below the 50th percentile: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*. Additionally, the following one measure scored statistically significantly lower in 2020 than in 2018: *Getting Care Quickly*. Also, two of the nine measures scored below the 2019 NCQA adult Medicaid national averages: *Getting Needed Care* and *Getting Care Quickly*.

Finally, although final results for UHC CP QI's PIPs were not available in 2020, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center* and *Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64* rapid-cycle PIPs. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services.

'Ohana Community Care Services ('Ohana CCS) Results

Compliance Monitoring Review

The 2020 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-56 presents the standards and compliance scores for 'Ohana CCS.

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

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	38	31	31	0	0	7	100%
IV	Quality Assessment and Performance Improvement	10	10	10	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**101**	**93**	**92**	**1**	**0**	**8**	**99%**

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

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

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

Strengths

Overall, 'Ohana CCS performed above average on the compliance review, scoring 100 percent on seven of the eight standards reviewed in 2020.

Provider Selection:

'Ohana CCS confirmed through its participating provider agreement, provider manual, and network development policy that it had a comprehensive process for the selection of its network providers. The provider manual demonstrated that 'Ohana CCS communicated and supported network providers to advise and advocate for members regarding members' health status, medical care, treatment options, and

the right to participate in treatment decisions. 'Ohana CCS provided educational sessions in accordance with the behavioral health organization's (BHO's) provider education policy that informed providers about BHO operations, managed care, claims processing, UM, and member rights and responsibilities.

Credentialing:

'Ohana CCS demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing providers that effectively evaluated providers and complied with the NCQA credentialing standards and guidelines. Although 'Ohana CCS did not currently delegate credentialing functions, the BHO maintained a credentialing delegation policy and processes for pre-delegation audits, ongoing monitoring and oversight, as well as annual audits (formal review) of delegates.

Quality Assessment and Performance Improvement:

'Ohana CCS' comprehensive quality improvement program demonstrated that the BHO effectively evaluated access, timeliness, and quality of services provided to CCS members. 'Ohana CCS prepared an annual quality improvement program description and quality improvement evaluation of the previous year's quality program achievements. The scope of the quality improvement program activities applied to specialized behavioral health services for eligible members determined to have an SMI or serious and persistent mental illness (SPMI) diagnosis. The quality improvement program description served as the basis for 'Ohana CCS' annual evaluation of its quality improvement program. The annual evaluation demonstrated that 'Ohana CCS evaluated the overall effectiveness of its quality improvement program through the use of data, analysis, measurement against goals, identification of accomplishments and any barriers to achieving goals, and recommendations for the coming year.

Health Information Systems:

'Ohana CCS demonstrated its ability to collect, analyze, integrate, and report data on utilization, service coordination, claims, grievances and appeals, service utilization, and disenrollments, among others. 'Ohana CCS had processes in place to verify the accuracy and completeness of its claims and encounter data by conducting claims audits and running the data through various system edits within its claims and encounter data reporting systems. The health plan also had data security measures, policies, and plans related to disaster planning and recovery and business continuity.

Practice Guidelines:

'Ohana CCS had numerous CPGs for behavioral health disorders, including anxiety disorders, depressive disorders in children and adolescents, schizophrenia, substance abuse disorders, and suicidal behavior. The CPGs supported quality and efficiency of care by establishing guidance to improve care for behavioral health, chronic disease, and preventive care. Links to the CPGs were available to providers on the BHO's website through the provider portal, and information regarding the online CPGs and other provider resources were published in provider newsletters or the provider manual. The BHO CPG policy and procedure identified that CPGs would be available for review and dissemination upon a member's request.

Program Integrity:

'Ohana CCS had a compliance plan and several policies and procedures that guided the health plan's compliance program. 'Ohana CCS provided initial onboarding and annual training to all employees about various compliance topics including identification and reporting of suspected FWA, employee code of conduct, whistleblower and non-retaliation laws, and privacy and security. The health plan implemented various processes to monitor provider billings, review providers for over- or underutilization, and investigate reports of suspected FWA. 'Ohana CCS also had processes in place to report overpayments to the State.

Enrollment and Disenrollment:

'Ohana CCS had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. As all member enrollment and disenrollment decisions were made by the State, 'Ohana CCS customer service staff members referred health plan members to the State eligibility worker in the event the member wanted to request disenrollment from the health plan. 'Ohana CCS did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State when it became aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

'Ohana CCS was found to be 95 percent compliant with the Subcontracts and Delegation standard, with one element scoring a *Partially Met.* The health plan had several executed subcontracts for various health plan administrative functions. 'Ohana CCS had policies and procedures for monitoring, oversight, and evaluation of its delegated entities. A review of the subcontracts revealed that the medical record retention requirements were inconsistent with the State's retention policy of 10 years. The corrective action required by 'Ohana CCS was to amend the subcontracts to include a provision that the subcontractor must retain medical records in compliance with the State's health plan contract (10 years).

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 selected to use seven standard and two 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 2020 measure reporting.

The auditors did not have any recommendations for ‘Ohana CCS.

‘Ohana CCS was required to report the BHA measure, which received the audit result of *Reportable*. For ‘Ohana CCS reporting, the *Follow-Up After Emergency Department Visit for AOD Abuse and Dependence—7-Day Follow-Up—13–17 Years* and *30-Day Follow-Up—13–17 Years* measure indicators received a designation of *Small Denominator* (NA).

‘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 and Risk-Adjusted Utilization Performance Measure Results

‘Ohana CCS’ Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-57. Three rates in this domain demonstrated a relative improvement of more than 9 percent in HEDIS 2020. Additionally, two measure rates that could be compared to national benchmarks fell below the 50th percentile, including one measure rate that fell below the 25th percentile. One measure rate met or exceed the 50th percentile. The *Ambulatory Care—Total (per 1,000 Member Months)—Outpatient Visits—Total* measure rate is 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 2020.

Table 3-57—‘Ohana CCS’ HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	130.46	86.92	-33.37%	★
Outpatient Visits—Total	634.10	417.80	-34.11%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total—Total	33.33%	43.69%	31.08%	★★★
Engagement of AOD Treatment—Total—Total	9.88%	10.83%	9.62%	★★

** For this indicator, a lower rate indicates better performance.*
NC indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Behavioral Health Performance Measure Results

'Ohana CCS' Behavioral Health performance measure results are shown in Table 3-58. One measure rate within this domain reported a relative improvement of more than 10 percent in HEDIS 2020. Additionally, four measure rates ranked at or above the 75th percentile, with three of these rates exceeding the 90th percentile. Conversely, six measure rates fell below the 50th percentile, with two of these measure rates falling below the 25th percentile. Additionally, eight measure rates in this domain had a relative decline of more than 10 percent in HEDIS 2020. Two measures[3-36] in this domain had an MQD Quality Strategy target for HEDIS 2020, and 'Ohana CCS met or exceeded both of the established targets, the 75th percentile.

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

Measure	HEDIS 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	70.24%	71.95%	2.43%	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	41.63%	46.12%	10.79%	★
Effective Continuation Phase Treatment	33.47%	30.58%	-8.63%	★
Behavioral Health Assessment				
BHA Completion Within 14 Days of Enrollment (Within Standard)	—	40.00%	—	NC
BHA Completion Within 15–30 Days of Enrollment (Not Within Standard)	—	16.86%	—	NC
BHA Completion Within 31–60 Days of Enrollment (Not Within Standard)	—	7.57%	—	NC
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence				
7-Day Follow-Up—13–17 Years	NA	NA	—	NC
7-Day Follow-Up—18+ Years	13.10%	10.31%	-21.30%	★★
7-Day Follow-Up—Total	13.10%	10.31%	-21.30%	★★
30-Day Follow-Up—13–17 Years	NA	NA	—	NC
30-Day Follow-Up—18+ Years	23.96%	16.49%	-31.18%	★★
30-Day Follow-Up—Total	23.96%	16.49%	-31.18%	★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total	54.04%	44.50%	-17.65%	★★★
30-Day Follow-Up—Total	76.30%	65.50%	-14.15%	★★★★
Follow-Up After Hospitalization for Mental Illness				

[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 2019 Rate	HEDIS 2020 Rate	Relative Difference	2020 Performance Level
7-Day Follow-Up—Total	66.44%	52.75%	-20.61%	★★★★★
30-Day Follow-Up—Total	82.53%	72.75%	-11.85%	★★★★★

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
NA indicates that the 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.
2020 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentiles*
★★★ *= 50th to 74th percentiles*
★★ *= 25th to 49th percentiles*
★ *= Below the 25th percentile*

Conclusions and Recommendations

Based on HSAG's analyses of the 14 'Ohana CCS measure rates with comparable benchmarks, six of these measures rates (42.9 percent) ranked above the 50th percentile, with four of these rates (28.6 percent) ranking 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 (21.4 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 and Risk-Adjusted Utilization
  - *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*
- Behavioral Health
  - *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*

Validation of Performance Improvement Projects

For validation year 2020, 'Ohana CCS submitted two state-mandated PIPs for validation—*Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge* and *Follow-Up After Emergency Department Visit for Mental Illness*. These rapid-cycle PIPs were implemented in July 2019. The PIP topics represent key areas of focus for improvement and are part of the MQD Quality Strategy.

Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. The focus of the *Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge* PIP is to increase the compliance for seven-day follow-up visits after hospitalization for mental illness or intentional self-harm among members 18 years of age and older who are assigned to the selected community-based case management (CBCM) agencies. The focus of the *Follow-Up After Emergency Department Visit for Mental Illness* PIP is to increase the percentage of

follow-up within 7 days post-ED visits for mental illness or intentional self-harm for members 18 years of age and older, who are assigned to ‘Ohana Health Plan and The Institute for Human Services (IHS).

Findings

‘Ohana CCS successfully achieved all validation criteria in Modules 1 through 3 for both PIPs, addressing all recommendations. The health plan progressed to testing interventions for the rapid-cycle PIPs in the 2020 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plan will complete the final Module 4 and Module 5 submissions, including SMART Aim measure outcomes and intervention testing results, for the 2021 annual validation.

For each PIP topic, in Module 1, ‘Ohana CCS determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global Aim and SMART Aim, and developed the key driver diagram. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. In Module 2, ‘Ohana CCS defined how and when it will be evident that improvement is being achieved.

Table 3-59 outlines ‘Ohana CCS’ SMART Aim for each PIP.

Table 3-59—PIP Topic and SMART Aim Statements for ‘Ohana CCS

PIP Topic	SMART Aim Statement
Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge	By 1/31/2021, increase the percentage of follow-up post-hospitalization within seven days for those discharged for mental illness among members ages 18 and older who are assigned to the selected community-based case management (CBCM) agencies (Aloha House, Community Empowerment Resources, and Hope Inc.) from 50% to 65.25%.
Follow-Up After Emergency Department Visit for Mental Illness	By 1/31/2021, increase the percentage of follow-up within 7 days post-ED visits for mental illness or intentional self-harm for members (ages 18 and older) who are assigned to ‘Ohana Health Plan and The Institute for Human Services (IHS) from 44.68% to 53.00%.

In Module 3, for each PIP, ‘Ohana CCS completed a process map and an FMEA to determine the areas within its process that demonstrated the greatest need for improvement, have the most impact on the desired outcomes, and can be addressed by potential interventions. Table 3-60 and Table 3-61 summarize the potential interventions ‘Ohana CCS identified to address high-priority subprocesses and failure modes determined in Module 3.

Table 3-60—Intervention Determination Summary for the *Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge* PIP for 'Ohana CCS

Failure Modes	Potential Interventions
Case manager (CM) does not contact the facility to arrange for the visit while the member is inpatient.	Care coordinator notifies CM liaison of the member's admission. CM liaison will track members from the time they admit as inpatient, up to two to three days post-discharge, and communicate with the assigned CM at the CBCM agency until the member is scheduled a follow-up appointment with a behavioral health (BH) provider within seven days of discharge.
CM does not arrange an in-person visit with the member during facility admission, prior to discharge.	Send a reminder notification to the CBCM agency if the visit during the member's inpatient admission is not captured in CellTrak (electronic health record [EHR]) within 24 hours. The reminder to the CBCM agency is to notify the agency that the visit had not been captured in CellTrak (if the visit had occurred). If the visit has not occurred and the member has not been discharged, it will be a reminder to visit the member.
CM is not trained and is unaware of the importance of meeting with the member prior to discharge and lacks supervision in initiating the next steps to meet with the member at the facility.	Work with the selected CBCM agencies and learn the process of new staff onboarding and training to identify the gaps in training. Then, work with these agencies to incorporate the CM to meet with the member at the facility while inpatient and plan for the member's care after discharge to ensure the follow-up appointment is made within seven days post-discharge. The health plan will monitor the *FUH* rates monthly.

The health plan chose to test the "Bi-directional communication between CM liaisons and member's assigned case managers until the members successful completes the follow-up within seven days" intervention. The health plan initiated the intervention is May 2020. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Table 3-61—Intervention Determination Summary for the *Follow-Up After Emergency Department Visit for Mental Illness* PIP for 'Ohana CCS

Failure Modes	Potential Interventions
No real-time ED census data.	CMs at the health plan and IHS will receive real-time ED discharge notifications for members so they are aware that the members need follow-up appointments within seven days post-ED discharge. The CM liaison will receive the real-time census from a contracted vendor, Hawaii Health Information Exchange (HHIE)—Notify reporting system. CM liaisons assigned to the health plan—Acuity Level 5 team and IHS will send their assigned members' real-time ED visit notifications to the CMs.
Facility is busy and it is not a priority to notify the health plan of a member's visit to the ED.	Work with EDs across the State to provide the health plan's customer service number. The EDs should inform the health plan when a member visits the ED.
Member does not attend the scheduled visit on the date of the appointment due to transportation not having been set up to attend the visit.	Work with the CBCM agencies to identify the gaps in helping to arrange the follow-up visit for members and educate the agencies on how they can arrange transportation for members to attend the follow-up appointment.

Failure Modes	Potential Interventions
Member does not see the value in attending the appointment.	Work with the CBCM agencies to identify that CMs are educating members on the importance of engaging in care to improve their health.
Member has other priorities.	Work with the CBCM agencies to ensure that CMs are working closely with members to identify issues and priorities. Assist members in eliminating barriers, put their health first as a priority, and engage in care.

The health plan chose to test the "Utilizing Hawaii Health Information Exchange (HHIE) reporting system to obtain ED discharge notifications on daily a basis (real-time) and CM liaisons will relay the information to the selected CBCMs" intervention. The health plan intended to begin intervention testing in April 2020; however, due to operational challenges, the intervention could not begin until August 2020. The final intervention testing results and PIP conclusions will be submitted by the health plan for HSAG's review in April 2021.

Strengths and Weaknesses

'Ohana CCS designed a methodologically sound project for both PIPs and was successful in building quality improvement teams and establishing collaborative partnerships. The health plan also successfully completed Module 3 and identified opportunities for improvement and potential interventions to address the identified flaws or gaps.

Recommendations for Improvement

Based on the 2020 PIP validation, HSAG recommends the following:

- 'Ohana CCS should ensure that each intervention selected for testing is a change to the current process, will address identified flaws or gaps, and is expected to have a positive impact on the SMART Aim measure.
- When planning a test of change, 'Ohana CCS should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- 'Ohana CCS should clearly identify and communicate the necessary steps that will be taken to carry out an intervention including details that define who, what, where, and how the intervention will be carried out when designing the intervention testing plan.
- To ensure a methodologically sound intervention testing methodology, 'Ohana CCS should determine the best method for identifying the intended effect of an intervention prior to testing. Intervention testing measures and data collection methodologies should allow the health plan to rapidly determine the direct impact of the intervention. The testing methodology should allow the health plan to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.
- The health plan should document COVID-19 pandemic-related challenges in Module 4 and Module 5 submissions, and clearly indicate if any modifications were made to the interventions based on those challenges.

- 'Ohana CCS should continue testing interventions for the PIP through the SMART Aim end date of January 31, 2021. 'Ohana CCS should reach out to HSAG with any questions it has during this time.

Overall Assessment of Quality, Access, and Timeliness of Care

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

Conclusions

In general, 'Ohana CCS' performance results illustrate good performance across the three EQR activities.

'Ohana CCS showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. 'Ohana CCS' performance during the 2020 compliance review was above average, meeting or exceeding the statewide compliance score for all eight standards. 'Ohana CCS achieved 100 percent compliance in seven standards and 95 percent in the *Subcontracts and Delegation* 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, six (42.9 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 targets, the 75th percentile.

Finally, although final results for 'Ohana CCS' PIPs were not available in 2020, the health plan was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the *Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge* and *Follow-Up After Emergency Department Visit for Mental Illness* rapid-cycle PIPs. The topics selected addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services.

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 2020 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 eight 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.

Table 4-1—Compliance Standards and Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
Provider Selection	90%	100%	90%	100%	100%	100%	**97%**
Subcontracts and Delegation	95%	100%	70%	95%	100%	95%	**93%**
Credentialing	100%	99%	99%	100%	100%	100%	**99%**
Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	**100%**
Health Information Systems	100%	100%	100%	100%	100%	100%	**100%**
Practice Guidelines	100%	100%	100%	100%	100%	100%	**100%**
Program Integrity	100%	95%	91%	100%	91%	100%	**96%**
Enrollment and Disenrollment	100%	100%	100%	100%	100%	100%	**100%**
Totals	**99%**	**99%**	**95%**	**99%**	**99%**	**99%**	**98%**

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

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. Four standards were found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—*Quality Assessment and Performance Improvement*, *Health Information Systems*, *Practice Guidelines*, and *Enrollment and Disenrollment*. The *Subcontracts and Delegation*, *Program Integrity*, and *Provider Selection* standards were identified as having the greatest opportunity for improvement, with statewide compliance scores of 93 percent,

96 percent, and 97 percent, respectively. While the *Subcontracts and Delegation* standard exhibited the lowest overall performance (93 percent), this statewide compliance score was largely driven by KFHP QI's low score (70 percent); the remaining health plans scored 95 percent (AlohaCare QI, 'Ohana QI, and 'Ohana CCS) and 100 percent (HMSA QI and UHC CP QI).

Total compliance scores were 99 percent for all health plans except for KFHP QI (95 percent). These results suggest an overall high degree of compliance with State and federal managed care requirements. Following the 2020 compliance monitoring reviews, each health plan received a detailed written report of findings and recommendations and was required to develop and implement a CAP for all items that were not scored *Met*. The MQD and HSAG reviewed and approved the health plans' CAPs and will continue to provide follow-up monitoring until all identified deficiencies are corrected.

'Ohana QI and 'Ohana CCS exceeded the statewide compliance score for all eight standards. KFHP QI was the lowest scoring plan, falling below the statewide score in three of the eight standards. The *Subcontracts and Delegation* and *Program Integrity* standards represented the greatest opportunity for improvement as all health plans required corrective actions in one or both of these standards.

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 2020 NCQA HEDIS Compliance Audit. 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 Systems 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*	*Fully Compliant*	*Fully Compliant*

HEDIS Performance Measure Results

This section of the report highlights health plans' performance for the current year by domain of care. Each table illustrates the health plans' 2020 measure rates and their performance relative to the NCQA national Medicaid HEDIS 2019 percentiles, where applicable.[4-1] The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the25th percentile

Access and Risk-Adjusted Utilization

Table 4-3 displays the Access and Risk-Adjusted Utilization measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-3—Comparison of HEDIS 2020 Access and Risk-Adjusted Utilization Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	61.35% ★	71.22% ★	80.05% ★★★	60.55% ★	58.05% ★
45–64 Years	73.90% ★	81.75% ★★	90.20% ★★★★	79.71% ★	78.72% ★
65 Years and Older	80.02% ★	85.97% ★★	95.82% ★★★★★	88.02% ★★	94.01% ★★★★
Total	67.47% ★	75.70% ★	84.91% ★★★	73.60% ★	76.85% ★★
Hospitalization for Potentially Preventable Complications					
Acute ACSC—Observed Discharges—Total	11.06 —	8.65 —	19.15 —	11.12 —	13.93 —
Acute ACSC—O/E Ratio—Total	0.78 —	— —	0.76 —	0.53 —	0.79 —
Chronic ACSC—Observed Discharges—Total	24.92 —	20.06 —	20.62 —	21.16 —	20.15 —
Chronic ACSC—O/E Ratio—Total	1.59 —	— —	0.83 —	0.93 —	1.11 —
Total ACSC—Observed Discharges—Total	35.99 —	28.72 —	39.71 —	32.27 —	33.75 —

[4-1] HEDIS 2020 performance measure rates were compared to HEDIS Quality Compass national Medicaid percentiles for HEDIS 2019.

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Total ACSC—O/E Ratio—Total	1.34 —	— —	0.95 —	0.83 —	1.06 —
Plan All-Cause Readmissions[1]					
*Index Total Stays—Observed Readmissions—Total**	8.37% —	9.26% —	10.12% —	10.53% —	10.37% —
*Index Total Stays—O/E Ratio—Total**	0.86 —	0.92 —	1.03 —	0.96 —	0.93 —

** For this indicator, a lower rate indicates better performance.*
[1] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends a break in trending between HEDIS 2020 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 Access and Risk-Adjusted Utilization performance measure domain, KFHP QI performed best among the health plans, with four measure rates ranking above the 50th percentile, two of which ranked at or above the 75th percentile. AlohaCare QI demonstrated the worst performance among the health plans, with four measure rates falling below the 25th percentile. Health plans demonstrated the worst performance for *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, with only one plan meeting the 50th percentile for this measure.

There were no measures in this domain with MQD Quality Strategy targets for HEDIS 2020.

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 2020 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	50.36% ★★	59.76% ★★★	45.28% ★★	49.15% ★★	46.96% ★★
Childhood Immunization Status					
Combination 3	64.48% ★	65.94% ★★	79.45% ★★★★★	56.43% ★	63.07% ★
DTaP	69.83% ★	74.21% ★★	82.51% ★★★★	62.38% ★	68.09% ★
Hepatitis B	82.00% ★	80.29% ★	90.82% ★★★	73.35% ★	81.16% ★
HiB	81.27% ★	87.59% ★★	87.32% ★★	74.92% ★	80.40% ★
IPV	81.51% ★	83.21% ★	90.52% ★★★	74.92% ★	80.40% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
MMR	82.48% ★	88.81% ★★★	91.25% ★★★★	74.92% ★	81.91% ★
Pneumococcal Conjugate	69.10% ★	75.67% ★★	80.03% ★★★	60.50% ★	68.09% ★
VZV	81.51% ★	87.35% ★★	90.52% ★★★	72.73% ★	80.90% ★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	54.26% ★	69.34% ★	83.22% ★★★	51.22% ★	54.60% ★
Combination 2 (Meningococcal, Tdap, HPV)	20.68% ★	33.09% ★★	43.94% ★★★★	23.17% ★	26.07% ★
HPV	25.55% ★	36.25% ★★	44.87% ★★★★	26.83% ★	29.14% ★
Meningococcal	56.93% ★	71.29% ★	84.29% ★★★	54.88% ★	59.20% ★
Tdap	62.77% ★	76.64% ★	85.35% ★★	56.91% ★	59.20% ★
Well-Child Visits in the First 15 Months of Life					
*No Well-Child Visits**	3.16% ★	1.72% ★★	0.33% ★★★★★	2.38% ★★	3.01% ★
Six or More Well-Child Visits	73.97% ★★★★★	71.26% ★★★★	79.28% ★★★★★	74.49% ★★★★★	76.19% ★★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	67.88% ★★	76.42% ★★★	82.99% ★★★★	63.66% ★	61.99% ★

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 eight measure rates ranking at or above the 75th percentile, three of which exceeded the 90th percentile. AlohaCare QI and UHC CP QI demonstrated the lowest performance among the health plans, with only one measure rate (*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*) ranking above the national Medicaid 50th percentile, and 14 and 15 measure rates ranking below the 25th percentile, respectively. Additionally, 'Ohana QI showed low performance, with 14 measure rates falling below the 25th percentile. Health plans demonstrated the lowest performance for *Childhood Immunization Status—HiB* and *Immunizations for Adolescents—Tdap*, with all health plans ranking below the national Medicaid 50th percentile for both measures. Health plan performance was best for the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* measure as all health plans performed at or above the national Medicaid 75th percentile for this measure.

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 2020. 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 2020 Women's Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Breast Cancer Screening					
Breast Cancer Screening	47.15% ★	58.86% ★★★	80.87% ★★★★★	50.82% ★	60.54% ★★★
Cervical Cancer Screening					
Cervical Cancer Screening	54.50% ★	68.13% ★★★★	78.73% ★★★★★	45.74% ★	53.53% ★
Prenatal and Postpartum Care[1]					
Timeliness of Prenatal Care	88.08% —	77.62% —	99.26% —	86.92% —	91.48% —
Postpartum Care	79.81% —	55.72% —	87.62% —	67.03% —	78.83% —

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 2020, NCQA recommends a break in trending between HEDIS 2020 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 Women's Health performance measure domain, KFHP QI performed best among the health plans, with two measure rates exceeding the 90th percentile. AlohaCare and 'Ohana QI demonstrated the worst performance among the health plans, with both measure rates falling below the 25th percentile.

There were three measures[4-2] within the Women's Health domain associated with an MQD Quality Strategy target in HEDIS 2020. KFHP QI was the only health plan to meet or exceed the target for two measures: *Breast Cancer Screening* and *Cervical Cancer Screening*.

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 2020 Care for Chronic Conditions Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Comprehensive Diabetes Care					
HbA1c Testing	88.08% ★★	85.40% ★★	95.01% ★★★★★	88.08% ★★	89.54% ★★★

[4-2] Due to technical specification changes for HEDIS 2020, comparison to benchmarks (i.e., the MQD Quality Strategy target) was not appropriate for the *Prenatal and Postpartum Care* measure.

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
*HbA1c Poor Control (>9.0%)**	35.28% ★★★	40.39% ★★	29.00% ★★★★	39.66% ★★	29.20% ★★★★
HbA1c Control (<8.0%)	53.53% ★★★	47.69% ★★	61.45% ★★★★★	51.58% ★★★	60.10% ★★★★
Eye Exam (Retinal) Performed	58.64% ★★	66.91% ★★★★	69.83% ★★★★★	65.45% ★★★★	70.56% ★★★★★
Medical Attention for Nephropathy	91.00% ★★★	86.37% ★	95.74% ★★★★★	91.48% ★★★	94.89% ★★★★★
Blood Pressure Control (<140/90 mm Hg)	59.85% ★★	59.12% ★★	80.29% ★★★★★	63.02% ★★	67.40% ★★★
COPD or Asthma in Older Adults Admission Rate					
40–64 Years	27.39 —	41.47 —	22.11 —	63.14 —	31.84 —
65 Years and Older	172.51 —	59.45 —	45.11 —	114.39 —	64.82 —
Total	56.51 —	43.48 —	25.53 —	78.25 —	46.68 —
Heart Failure Admission Rate					
18–64 Years	60.08 —	37.13 —	40.17 —	65.85 —	68.80 —
65 Years and Older	182.65 —	97.10 —	126.31 —	170.51 —	135.30 —
Total	71.71 —	40.14 —	46.13 —	84.80 —	88.28 —

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.*
— 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, KFHP QI performed best among the health plans, with all measure rates that could be compared to benchmarks ranking at or above the 75th percentile with five measure ratings at or above the 90th percentile. Additionally, UHC CP QI's performance was similar, with six measure rates ranking at or above the 50th percentile, two of which were at or above the 90th percentile. HMSA QI demonstrated the worst performance among the health plans, having five measure rates fall below the 50th percentile.

Five measures[4-3] within the Care for Chronic Conditions domain were associated with an MQD Quality Strategy target in HEDIS 2020. KFHP QI met or exceeded five targets, UHC CP QI met or exceeded three targets, AlohaCare QI and 'Ohana QI met or exceeded two targets, and HMSA QI met or exceeded one target.

[4-3] Within this domain, there were five 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)*.

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 2020 Behavioral Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	19.09% ★	38.69% ★★★	60.31% ★★★★★	33.19% ★★	32.43% ★★
30-Day Follow-Up—Total	38.79% ★	59.64% ★★★	73.28% ★★★★★	53.28% ★★	47.45% ★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	21.95% ★	46.20% ★★★	65.98% ★★★★★	NA	NA
Continuation and Maintenance Phase	NA	57.14% ★★★	NA	NA	NA
Screening, Brief Intervention, and Referral to Treatment					
SBIRT Training Plan Submitted to DHS/MQD	Met —	Met —	Met —	Met —	Met —
SBIRT Training Plan Recommendations from DHS/MQD Addressed	Met —	Met —	Met —	Met —	Met —
ATTC Certification Achieved (At Least 1 Person from MCO by 12/31/19)	Met —	Met —	Met —	Met —	Met —

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
"Met" indicates the health plan met the data element criteria.
— 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 exceeding the 90th percentile. Additionally, HMSA QI had four measure rates ranking at or above the 50th percentile. AlohaCare QI demonstrated the worst performance among the health plans, having all three of its reportable measure rates falling below the 25th percentile.

Two measures[4-4] within the Behavioral Health domain were associated with an MQD Quality Strategy target in HEDIS 2020. KFHP QI was the only health plan to meet or exceed the targets for both *Follow-Up After Hospitalization for Mental Illness* indicators.

[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*.

Summary of MQD Quality Strategy Targets

Table 4-8 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 4-8—Percentage of MQD Quality Strategy Targets Met or Exceeded for QI Population

Measure	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	Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Timeliness of Prenatal Care[1] (75th Percentile)	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
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)*	Met	Not Met	Met	Not Met	Met
Comprehensive Diabetes Care—HbA1c Control (<8.0%) (50th Percentile)	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
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

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Total MQD Targets Met	**2**	**2**	**10**	**2**	**3**
Percent MQD Targets Met	**20.00%**	**20.00%**	**100.00%**	**20.00%**	**30.00%**

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 2020, 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 10 applicable measures with MQD Quality Strategy targets. KFHP QI met or exceeded 10 of 10 (100.00 percent) MQD Quality Strategy targets, followed by UHC CP QI, which met or exceeded the MQD Quality Strategy targets for three of 10 (30.0 percent) measures. AlohaCare QI, HMSA QI, and 'Ohana QI each met two of 10 (20.0 percent) MQD Quality Strategy targets. These results, in combination with overall HEDIS measure rates, suggest considerable room for improvement for AlohaCare QI, HMSA QI, and 'Ohana QI in meeting the goals outlined in the MQD Quality Strategy.

Validation of Performance Improvement Projects

In 2020, HSAG validated two PIPs for each of the five QI health plans—AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI; and for one CCS plan—'Ohana CCS.' The PIP topics for all the QI health plans were based on the HEDIS measures *Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness*. The PIP topics for 'Ohana CCS were based on the HEDIS measures *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness*. For the 2020 validation, all health plans progressed to testing interventions in Module 4.

The health plans had not progressed to reporting PIP SMART Aim measure results. The SMART Aim measure end date for these PIPs is January 31, 2021. In April 2021, each health plan will submit completed Module 4s summarizing intervention evaluation results. The health plans will also submit Module 5 for each PIP with the key findings, outcomes achieved, and lessons learned. Healthcare outcome data and health plan comparative information will be available after the Module 4 and Module 5 submissions in the 2021 validation year.

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

Statewide Comparisons—QI Health Plans

Table 4-9 presents the 2020 percentage of top-box scores 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 4-9—Comparison of 2020 QI Adult CAHPS Results

	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	QI Program Aggregate
Global Ratings						
Rating of Health Plan	63.2%	57.6% ↓	69.8% ↑	62.5%	66.1%	64.3%
Rating of All Health Care	53.9%	50.9% ↓	67.5% ↑	55.3%	57.3%	57.7%
Rating of Personal Doctor	70.9%	61.3% ↓	73.5% ↑	68.7%	71.3%	69.4%
Rating of Specialist Seen Most Often	69.6%	60.4% ↓	75.5% ↑	68.9%	69.2%	69.2%
Composite Measures						
Getting Needed Care	75.1%	75.1% ↓	86.2% ↑	82.0%	79.6%	80.3%
Getting Care Quickly	74.4%	75.2%	82.5% ↑	82.7% ↑	77.8%	79.0%
How Well Doctors Communicate	93.9%	92.7%	96.6% ↑	92.4%	94.5%	94.0%
Customer Service	87.7%	79.8% ↓	90.9% ↑	87.0%	88.8%	87.3%
Individual Item Measure						
Coordination of Care	86.2%+	81.0% ↓	94.8% ↑	87.4%	89.3%	88.2%

Cells highlighted in yellow represent scores that are at or above the 2019 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are below the 2019 NCQA adult Medicaid national averages.
↑ Indicates the score is statistically significantly higher than the QI Program aggregate.
↓ Indicates the score is statistically significantly lower than the QI Program aggregate.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Comparison of the QI Program aggregate and QI health plans' scores to the 2019 NCQA adult Medicaid national averages revealed the following summary 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.

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

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

- AlohaCare QI did not score statistically significantly higher or lower than the QI Program aggregate on any of the measures.
- HMSA QI did not score statistically significantly higher than the QI Program aggregate on any of the measures. Conversely, HMSA QI scored statistically significantly lower than the QI Program aggregate 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*, *Customer Service*, and *Coordination of Care*.
- KFHP QI scored statistically significantly higher than the QI Program aggregate on nine measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. Conversely, KFHP QI did not score statistically significantly lower than the QI Program aggregate on any of the measures.
- 'Ohana QI scored statistically significantly higher than the QI Program aggregate on one measure, *Getting Care Quickly*. Conversely, 'Ohana QI did not score statistically significantly lower than the QI Program aggregate on any of the measures.
- UHC CP QI did not score statistically significantly higher or lower than the QI Program aggregate on any of the measures.

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

Table 4-10 presents the 2020 top-box scores for the Hawaii CHIP population.

Table 4-10—Comparison of 2020 CHIP CAHPS Results

Global Ratings	
Rating of Health Plan	72.6%
Rating of All Health Care	66.6%
Rating of Personal Doctor	76.7%
Rating of Specialist Seen Most Often	69.5%+
Composite Measures	
Getting Needed Care	80.4%
Getting Care Quickly	87.8%
How Well Doctors Communicate	95.9%
Customer Service	85.1%
Individual Item Measure	
Coordination of Care	82.3% ▼

Cells highlighted in yellow represent scores that are at or above the 2019 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2019 NCQA child Medicaid national averages.
▲ Indicates the 2020 score is statistically significantly higher than the 2019 score.
▼ Indicates the 2020 score is statistically significantly lower than the 2019 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Comparison of the CHIP population's 2020 scores to the 2019 NCQA child Medicaid national averages revealed the following summary results:

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

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

- The CHIP population's 2020 score was statistically significantly lower than the 2019 score on one measure, *Coordination of Care*.

NCQA Comparisons—QI Health Plans

Based on the comparison of the QI Program aggregate and each of the QI health plans' top-box scores to NCQA's 2019 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 4-11.[4-6]

Table 4-11—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 4-12 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 4-12—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	★★★ **64.3%**	★★★ **57.7%**	★★★ **69.4%**	★★★ **69.2%**
AlohaCare QI	★★★ 63.2%	★★ 53.9%	★★★★ 70.9%	★★★ 69.6%
HMSA QI	★★ 57.6%	★ 50.9%	★ 61.3%	★ 60.4%
KFHP QI	★★★★★ 69.8%	★★★★★ 67.5%	★★★★ 73.5%	★★★★★ 75.5%
'Ohana QI	★★★ 62.5%	★★★ 55.3%	★★★ 68.7%	★★★ 68.9%

[4-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
UHC CP QI	★★★★ 66.1%	★★★ 57.3%	★★★★ 71.3%	★★★ 69.2%

Table 4-13 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 composite measures and one individual item measure.

Table 4-13—NCQA Comparisons: Composite and Individual Item Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care
QI Program	★ **80.3%**	★ **79.0%**	★★★★ **94.0%**	★★ **87.3%**	★★★★ **88.2%**
AlohaCare QI	★ 75.1%	★ 74.4%	★★★★ 93.9%	★★ 87.7%	★★★ 86.2%+
HMSA QI	★ 75.1%	★ 75.2%	★★★ 92.7%	★ 79.8%	★ 81.0%
KFHP QI	★★★★ 86.2%	★★★ 82.5%	★★★★★ 96.6%	★★★ 90.9%	★★★★★ 94.8%
'Ohana QI	★★ 82.0%	★★★ 82.7%	★★★ 92.4%	★ 87.0%	★★★★ 87.4%
UHC CP QI	★ 79.6%	★ 77.8%	★★★★ 94.5%	★★ 88.8%	★★★★★ 89.3%

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.

One of the goals the MQD identified for the Hawaii Medicaid program is to improve member experience with health plan services. The MQD selected the following 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: *Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*.

- KFHP QI's and UHC CP QI's member experience ratings met or exceeded the 75th percentile for *Rating of Health Plan*.
- KFHP QI's member experience ratings met or exceeded the 75th percentile for *Getting Needed Care*.
- AlohaCare QI's, KFHP QI's, and UHC CP QI's member experience ratings met or exceeded the 75th percentile for *How Well Doctors Communicate*.

NCQA Comparisons—CHIP

Table 4-14 presents the overall member experience ratings and 2020 top-box scores for the Hawaii CHIP population on each of the four global ratings, four composite measures, and one individual item measure.[4-7]

Table 4-14—NCQA Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	72.6%	★★★
Rating of All Health Care	66.6%	★
Rating of Personal Doctor	76.7%	★★
Rating of Specialist Seen Most Often	69.5%+	★
Composite Measures		
Getting Needed Care	80.4%	★
Getting Care Quickly	87.8%	★★
How Well Doctors Communicate	95.9%	★★★★
Customer Service	85.1%	★
Individual Item Measure		
Coordination of Care	82.3%	★★

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

Comparison of the CHIP population's scores to NCQA's 2019 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The CHIP population did not score at or above the 90th percentile on any of the measures.
- The CHIP population scored below the 25th percentile on four measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service*.

[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.

5. Assessment of Follow-Up to Prior Year Recommendations

Introduction

This section of the annual report presents an assessment of how effectively the QI health plans addressed the improvement recommendations made by HSAG in the prior year (2019) 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 2019 compliance reviews were carried over to 2020. The specific compliance review findings and recommendations were reported in the 2019 EQR Report of Results. As appropriate, HSAG conducted technical assistance for the health plans and conducted the follow-up assessments of compliance.

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 2020 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

2019 NCQA HEDIS Compliance Audit Recommendations

The auditors did not have any recommendations for AlohaCare QI.

Improvement Activities Implemented

Not Applicable.

2019 HEDIS Performance Measure 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 for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
  - *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

Improvement Activities Implemented

Access to Care and Children's Preventive Health

AlohaCare assisted providers with telehealth services to promote access to care, which included providing hardware donations, Zoom licenses, and telehealth guidelines to ensure that members could access their providers despite face-to-face or in-office limitations due to the pandemic. AlohaCare staff also helped call network providers to help members secure timely specialty care appointments, when needed. When appropriate, AlohaCare utilized out-of-network providers to ensure members received access to needed care. Our "Timely Access Report" findings did indicate that the wait for PCP pediatric sick visits declined slightly over the year of 2019. In order to address this, a targeted letter was sent to the individual providers that did not meet the Access and Availability standards. The letter included information to ensure that providers are offering timely access according to the medical standards, and included a table summarizing the standards. Additionally, the Access and Availability standards were also included in the provider newsletter.

To promote PCP recruitment in 2019, AlohaCare repapered the network and updated provider agreements to include simpler provider-friendly language and a more transparent compensation exhibit.

Despite the pandemic, AlohaCare implemented several interventions in 2020 to improve measures capturing children's preventive health. AlohaCare undertook an omni-approach to improve outreach and communication. Automated campaign messages via text and interactive voice recordings (IVRs) were used to educate and remind parents/legal guardians about well-child visits and vaccinations listed above. Postcard reminder mailers were sent to parents/legal guardians of children between 3 to 6 years old and adolescents who missed their annual PCP checkup. Live telephonic calls were made to assist with scheduling visits. In September AlohaCare launched a member incentive program to target noncompliant members eligible for these measures, as well as rolled out its Provider Pay for Performance Program, which included incentives for well-child visits and childhood immunizations.

In addition, AlohaCare continued to focus on work to promote EPSDT, and the EPSDT coordinator provided extensive outreach to encourage pediatric visits that would include screening, vaccination, and exams.

Women's Health

AlohaCare implemented several interventions in 2020 to improve measures for women's health. Automated campaign messages via text and IVR were used to educate pregnant members about the

importance of prenatal and postpartum care. Live telephonic calls by lead care managers were made to assist with scheduling visits. In September AlohaCare launched a member incentive program to target noncompliant members eligible for prenatal/postpartum care and chlamydia screening, as well as rolled out its Provider Pay for Performance Program, which included incentives for prenatal/postpartum care and breast cancer screening.

Care for Chronic Conditions

AlohaCare implemented several interventions in 2020 to improve *Comprehensive Diabetes Care—Medical Attention for Nephropathy*. Automated campaign messages via text and IVRs were used to educate diabetic members about the importance of kidney screenings and kidney health with diabetes. In August AlohaCare rolled out its Provider Pay for Performance Program, which included incentives for addressing medical attention for nephropathy.

Behavioral Health

AlohaCare implemented a comprehensive intervention in 2020 to improve *Follow-Up After Hospitalization for Mental Illness*. In April AlohaCare contracted with Care Hawaii to service the follow-up visit, or assist coordination with the member's established behavioral health provider, and assist with appropriate program placement.

AlohaCare has not focused specifically on *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* or *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* other than to generally provide care management services to complex members and to support testing and management of diabetes for all members through our partnership with Hawaii's community health centers (CHCs), but will seek to focus on these areas in 2021. AlohaCare did recently (Q4 2020) create a new role and hire an experienced behavioral health director who will, among other things, focus on improvement of quality for this population.

CAHPS—Child Survey

2019 Recommendations

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 5-1 provides a summary of the key drivers identified for AlohaCare QI.

Table 5-1—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.

Improvement Activities Implemented

To the first point: It is widely acknowledged that certain specialty care services are more difficult to obtain in Hawaii due to statewide shortages. AlohaCare assisted providers with telehealth services to promote access to care, which included providing hardware donations, Zoom licenses, and telehealth guidelines to ensure that members could access their providers despite F2F or in-office limitations due to the pandemic. AlohaCare staff also helped call network providers to help members secure timely specialty care appointments, when needed. When appropriate, AlohaCare utilized out-of-network providers to ensure members received access to needed care. Our "Timely Access Report" findings did

indicate that the wait for PCP pediatric sick visits declined slightly over the year of 2019. In order to address this, a targeted letter was sent to the individual providers that did not meet the Access and Availability standards. The letter included information to ensure that providers are offering timely access according to the medical standards, and included a table summarizing the standards. Additionally, the Access and Availability standards were also included in the provider newsletter.

To promote PCP recruitment in 2019, AlohaCare repapered the network and updated provider agreements to include simpler provider-friendly language, and a more transparent compensation exhibit.

To the second point: AlohaCare's quality improvement team continues to work closely with providers to ensure that patient communication is delivered in a manner that is patient centric. Our plan encourages the use of motivational interviewing and patient-centered decision making. We believe that better patient care is a long-game. In 2020, AlohaCare began co-development of a program with the Hawaii Primary Care Association and 13 of Hawaii's CHCs that will support the further development of Hawaii's CHCs as truly transformed Patient-Centered Medical Homes (PCMHs). One component of this model is an emphasis on motivational interviewing and patient-centered decision making.

To the third point: AlohaCare has been a strong proponent of data integration, with a focus on full integration with all of Hawaii's CHCs who see more than half of our children. AlohaCare pays for a considerable portion of the costs related to the CHCs' chosen population health tools. These tools provide insight to the care their patients receive outside of their walls, bringing awareness of care the patient received from other doctors or health providers. As with the last bullet point, we believe an increased focus on supporting PCMH transformation encourages use of tools like Azara with which care teams can do pre-visit planning and call up information about care children received between visits.

To the fourth point: In late 2019, AlohaCare integrated care gap information from population health software into Guiding Care (G8) Care Management software. Customer service representatives were trained to use this information to remind members who called about needed care and help them determine where they can get needed care. Also in 2019, staff gained access to the ESI/MEDCO systems to assist in real time with pharmacy claim status, which helps customer service reps access information about a member's pharmacy-related questions quickly instead of having to return the call later after an exploratory inquiry was submitted to the pharmacy department. Additionally, the team was trained with V code look up in QNXT claims to find appliance and exam eligibility. Having easier access to information that can be used to respond to member questions improves satisfaction.

AlohaCare also made significant updates to our website, including the prominent publishing of the member-facing info@alohacare.org email account that goes to customer service. This contact significantly increased the number of inquiries received via email. The percentage of inquiries from members has been steadily increasing from under 30 percent in Q1 2019 to over 70 percent in Q2 2020.

Customer service is currently undergoing a PDSA for IVR/phone queue. The goals are to decrease wait time and utilize any wait time to provide member education, including messages that are timely for parents (e.g. back to school exam/vaccinations, free immunizations, and well-child programs). The system will be designed in such a way that AlohaCare can provide additional, seasonally adjusted or rotating content to assist members with their children's care.

To the fifth point: AlohaCare's quality improvement team continues to work closely with providers to ensure that forms, surveys, and other information are distributed in a manner that is patient-centric, and ensures that at a minimum:

- Information is translated into the primary language of the member.
- Text is clear and concise, with easy-to-understand instructions so members understand what they are filling out and why.

HMSA QUEST Integration (HMSA QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2019 NCQA HEDIS Compliance Audit Recommendations

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 QI continue to identify ways to improve its medical record over-read process to avoid any critical errors.

Improvement Activities Implemented

HMSA began working with 'Ohana to improve the quality of the CCS population data file for use in November 2019; however, a decision was made by 'Ohana to discontinue the file transmission to all health plans in 2019 due to the lack of use by other health plans.

HMSA QI modified its HEDIS data preparation 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 updated process was successfully implemented with no minimum required sample size (MRSS) issues in HEDIS 2020.

2019 HEDIS Performance Measure 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*

Improvement Activities Implemented

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 June of 2020, in partnership with HMSA, the Queen's Health Systems opened a new clinic, Empower Health, in Ewa to increase primary care access.

In addition, HMSA continues to provide member education materials, such as articles in Island Scene, our quarterly member magazine, our QUEST Integration website, and our QUEST Integration member

newsletter to increase member awareness of their care options and to help members understand their role in obtaining appropriate care in a timely and satisfactory manner.

HMSA's behavioral health partner, Beacon Health Options (Beacon), utilizes an integrated health approach to improve behavioral health outcomes by outreaching to both members and their providers.

Outreach to members and providers on the importance of early identification and treatment of substance use disorders is a key component of recovery and increases in member initiation of treatment is the first step. Beacon conducted provider education in March 2020; a toolkit was provided to each Physician Advisory Committee member that provided information about the HEDIS IET measure as the primary activity to improve initiation and engagement of alcohol and other drug dependence treatment.

In addition to the telephonic Aftercare outreach program, Beacon continued face-to-face visits conducted by the service coordinators. Service coordinators contact the facility (Maui Memorial Medical Center, Hilo Medical Center, Queen's Medical Center) at a minimum twice a week to discuss who is inpatient. For Castle Medical Center, Beacon contacts the facility twice a day to coordinate with the discharge planner. In conjunction with Aftercare, service coordinators supported facilities with discharge planning and engaged members in post-hospitalization follow-up care.

Children's Preventive Health

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

HMSA's quality payment programs have historically included (and continue to include) a measure for childhood immunizations, which encompasses Hepatitis B and Varicella. Adolescent immunizations is also a program measure which encompasses Tdap, meningococcal, and Gardasil.

Children and adolescent members are also participants of HMSA's EPSDT program, which follows the Bright Futures screening and periodicity schedule. On a monthly basis, HMSA sends members age-specific mailers that remind them to complete their well-child exams, which include applicable vaccinations. These mailers were paused from April 2020 to July 2020 due to COVID-19 restrictions; however, they were resumed in August 2020.

Provider and member reminder efforts involved providing vaccination status of members to providers. HMSA field staff outreached providers with their members' reports of vaccines received and not received.

Women's Health

HMSA engages with FQHCs to obtain chlamydia testing data for clinical outcomes reporting. The State has free testing available for which HMSA does not receive claims. We will facilitate discussions with Waianae Comprehensive Health to collect this data.

HMSA's Pregnancy and Postpartum Support 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. To improve outreach to QUEST Integration members, the Pregnancy and Postpartum Support Program is working with participating FQHCs to identify newly diagnosed pregnant members and offer additional resources.

The Pregnancy and Postpartum Support Program is featured in advertisements in the summer and winter issues of our *Island Scene* magazine.

Care for Chronic Conditions

HMSA has been working to design a program founded on the concept that all service coordinators should be able to provide disease self-management support rather than a dedicated small group, which is consistent with our approach for commercial and Medicare lines of business.

HMSA has developed workflows that leverage Model of Care resources like CDEs (certified diabetes educators) and combined them with current service coordination processes like complex case meetings.

In a disease management/self-management support program, members would need to be seen at greater frequency than they are currently under service coordination. HMSA has taken that into account and will utilize the case acuity function in the Coreo platform to allow service coordinators to give greater weight to the cases for those members who will be served by this program.

HMSA has developed workflows, assessments, education for staff, and referral processes to facilitate the implementation of this program. The development stage is almost complete—we will provide education and do a pilot project in December 2020 with complete roll out planned for January 2021.

Behavioral Health

During interaction with members, service coordinators discuss the importance of medication and treatment adherence, any laboratory tests that are required, community resources, and self-management techniques. Members are encouraged to discuss their results with their PCP or ordering physician.

CAHPS—Child Survey

2019 Recommendations

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 5-2 provides a summary of the key drivers identified for HMSA QI.

Table 5-2—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.			✓
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.

Improvement Activities Implemented

HMSA administers an annual patient satisfaction survey to members whose PCPs participate in the Payment Transformation Program. The survey covers topics related to engagement, access, and specialist care, and many of the survey questions align with the CAHPS survey. As of 2020, provider-level report cards that summarize the patient satisfaction survey results are generated and shared with PCPs and Provider Organizations. Provider Organizations are encouraged to discuss with their PCPs opportunities to impact our members' experience with care in the delivery system.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2019 NCQA HEDIS Compliance Audit Recommendations

The auditors did not have any recommendations for KFHP QI.

Improvement Activities Implemented

Not Applicable.

2019 HEDIS Performance Measure 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*

Improvement Activities Implemented

Access to Care

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*

The following table depicts the three-year trend results for *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total (IET)* measures recommended for improvement. HEDIS 2020 results indicate that improvement was achieved during MY 2019 for both sub measures.

	2018 Final Rate	2019 Final rates	2020 Final Rate
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: Total	41.95%	33.19%	40.27%
Engagement of AOD Treatment: Total	13.84%	8.35%	8.82%

An evaluation of the barriers and the activities implemented as part of our Quality Improvement process are also outlined as follows:

A 7 percent improvement has been seen in the *Initiation of AOD Treatment—Total* sub measure HEDIS 2020 rate. A 0.45 percent improvement has been seen in the *Engagement of AOD Treatment—Total* sub measure HEDIS 2020 rate.

Barriers:

- Newly on-boarded providers don't consistently receive education on standardized processes for HEDIS mental health measures.
- Difficulty filling open positions and high turnover of mental health providers.

Activities:

- Daily tracking cohort reports identifying patients with Index Prescription Start Date (IPSD) generated by the analytics team.
- Identified a team of providers in integrated behavioral health (IBH) to monitor the report on a daily basis to ensure appointments are scheduled within 14 days of the IPSD. IBH staff to send reminders to providers who made the initial Chemo Dependency diagnosis to refer patients for services.

- Recommended a standardized on-boarding process to educate new providers about HEDIS measures in all departments.
- Encourage PCPs to utilize mental health integration MHI providers for warm hand-offs when substance abuse is diagnosed.
- Research numerator fails for opportunities to improve follow-up.

Children's Preventive Health

- *Adolescent Well-Care Visits*

The following table depicts the three-year trend results for the *Adolescent Well-Care Visits (AWC)* measure recommended for improvement. HEDIS 2020 results indicate that improvement was achieved during MY 2019.

	2018 Final Rate	2019 Final rates	2020 Final Rate
Adolescent Well-Care Visits (awc)	43.31%	42.34%	45.28%

An evaluation of the barriers and the activities implemented as part of our Quality Improvement process are also outlined as follows:

A 2.94 percent improvement has been seen in the AWC HEDIS 2020 rate.

Barriers: Processes for booking adolescent well-care visits varied among providers.

Activities:

- Discussions on performance improvement began in fall of 2019; PDSA testing began June 1, 2020.
- Clinical team began using well-child visit tool to identify members eligible for an annual well-care visit.
- Once member is identified as eligible, they are added to the waitlist for the appropriate month to be scheduled.
- When the schedule becomes available, the member is scheduled from the wait list and an appointment is mailed.
  - To help increase compliance, members receive automated appointment reminders, including recently added text message reminders.

CAHPS—Child Survey

2019 Recommendations

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 5-3 provides a summary of the key drivers identified for KFHP QI.

Table 5-3—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.

Improvement Activities Implemented

Timeliness of Access

- The Kaiser Permanente Quality Improvement Team actively monitors timeliness of access to care for our QI patients. In the first quarter of 2019, 93.8 percent of patient requests seeking routine care were able to schedule an appointment within the standard of 21 days. In reviewing trends in pediatric appointment type utilization, our pediatric population preferred in-person appointments, when they need it. This resulted in creating a flexible appointment type that could be scheduled as an in-person visit, telehealth visit, or video visit based on patient preference. As a result, in the fourth quarter of 2019, 98.4 percent of patient requests seeking routine care were able to schedule an appointment within the standard of 21 days.
- As an integrated system, Kaiser Permanente Hawaii has the internal network and resources to provide pediatric specialty care for our pediatric population. Our primary care providers continually partner with specialty providers to ensure that we have appropriate access to services for our patients. For those patients seeking specialty services, 93.2 percent were able to schedule an appointment within the 4-week standard. However, there are situations that require us to refer patients to specialists in the community, which may be limited, especially on neighbor islands. This requires our health care team to continually outreach with these community providers to ensure that our patients receive access to care.

Quality of Care

- The quality of care we provide includes the experience our patients have with our providers. Our providers continually work on engaging our patients and families with shared decision making. This requires our providers to review the patient's chart, practice active listening, demonstrate empathy, and offer options for care. Our providers continuously monitor their feedback from their encounter-based Patient Satisfaction Survey and identify areas for improvement.

'Ohana Health Plan QUEST Integration ('Ohana QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2019 NCQA HEDIS Compliance Audit Recommendations

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

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

Improvement Activities Implemented

Processes have been implemented to assure that only supplemental data sources that are specific to 'Ohana are reflected in the HEDIS Roadmap documentation. Validation is completed by the quality improvement director who reviews the HEDIS Roadmap Section 5 for accuracy and completeness prior to submission.

2019 HEDIS Performance Measure 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*

Improvement Activities Implemented

2020 Medicaid Partnership for Quality (P4Q) Program

- 'Ohana's 2020 Medicaid Partnership for Quality (P4Q) program 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. 'Ohana supports members by working to educate them about the program, providing virtual meetings on at least a quarterly basis to discuss 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 education on coding and standards of care.

2020 Healthy Rewards

- The 'Ohana Health Plan Healthy Rewards Program incentivizes and encourages members to take care of their health by providing Visa debit cards, gift cards, and/or bonus rewards to those who complete specific preventive health, wellness, and engagement activities. The incentive program is

tailored to members based on their individual healthcare needs and includes 11 HEDIS measures and annual health screening. HEDIS measures include: Well Child 15, Well Child 34, Adolescent Well Visit, Prenatal Timeliness, Postpartum Care, Diabetes HbA1c Test, Cervical Cancer Screening, Breast Cancer Screening, Behavioral Health Follow Up, and Substance Abuse Initiation and Engagement. In addition, the program incentivizes eligible members to receive tobacco cessation counseling and new member Health Risk Assessment (HRA) completion with PCP visit.

Focused Call Campaigns

- 'Ohana's patient care advocates (PCAs) conduct outbound calls to members and encourage them to make an appointment or directly help them schedule an appointment with their PCP. This year, specific call campaigns were designed to identify and call members for focused outreach. These included Children's Preventive Health, Women's Health, and Behavioral Health call campaigns. If the PCA is unable to reach the member by telephone after multiple attempts, an unable to contact letter for established patients is sent that identifies services that are overdue and asks the member to contact their PCP (name and phone number included in the letter). The letters also include information on how to schedule transportation with the PCA's phone number 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 the member 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*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*

Improvement Activities Implemented in 2020:

- Quality practice advisors (QPAs) identify providers' appointment time frames and conduct provider education on annual wellness visits, EPSDT visits, as well as well-care and well-child visits in accordance with specified age groups and time frames.
- PCAs encourage members to conduct their annual wellness visits, EPSDT visits, and well-care and well-child visits by engaging members via call campaigns and member incentives.
- **ADDED NEW 2020** The provider educational flyer was created by and enterprise-wide IET workgroup that 'Ohana Health Plan took part in, in late 2019. The flyer was approved for 'Ohana Health Plan in 2020.
- **ADDED NEW 2020** CCS team plans to educate community-based case management (CBCM) agencies specifically on the IET measure and have them communicate with the member's PCP on not diagnosing them, rather referring member to their behavioral health (BH) provider to rule out the possibility of SUD. If this intervention does not show positive results, the next phase will be to

assess the program to include the measure as part of its incentive program such as scorecard. Finally, if the incentive results as ineffective intervention, health plan will reassess for a new improvement plan.

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*

Improvement Activities Implemented in 2020:

- Birthday cards are sent to pediatric and adolescent members turning one to 20, two months in advance of their birthday month, as a reminder to go into their PCP'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 two months turning one to 20 that have not had a visit to see their PCP'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.
- PCAs 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.
- Reminder text campaign to parents/guardians in June 2020 targeted to non-compliant members for the following measures: *Well-Child Visits in the First 15 Months of Life*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Childhood Immunization Status*, and *Immunizations for Adolescents*.
- Healthy Rewards for well-child visits in the third, fourth, fifth, and sixth years of life. Parents/guardians are given the option of 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.
- QPAs and/or PCAs provide providers with non-compliant member lists.
- Providers are mailed non-compliant member lists for members not seen for more than 120 days.
- Medicaid P4Q Program:
  - Provider receives $50 incentive for every member that completes their *Well-Child Visits in the First 15 Months of Life*.

  - Provider receives $50 incentive for every member that completes their *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.
  - Provider receives $50 incentive for every member that completes their *Childhood Immunization Status—Combination 10*.

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*

Improvement Activities Implemented in 2020:

- Prenatal and postpartum member outreach.
- Healthy Rewards Program: $25 for prenatal and postpartum care.
- Bonus Rewards for prenatal/postpartum care: Choice of stroller, car seat, playpen, or diapers upon completion of prenatal and postpartum care visit.
- Medicaid P4Q Program: Provider receives $40 incentive for every member that completes their prenatal/postpartum care visit.
- Provided education to OB/GYN providers using Women's Health HEDIS Toolkit, which includes all women's health related HEDIS measures.
- Disease Management outreach to high-risk pregnant members.
- BabySteps Care Management Program: Provides all pregnant members with care management services, education, and support.
- Maternal Personal Concierge Program to be implemented: Through customized and automated sets of text messages and an option for member to chat with care providers using member's mobile device, this program will engage with women during pregnancy, and mothers/caregivers of children up to 8 years old to improve:
  - Prenatal and postpartum mother and infant health.
  - Office visits during pregnancy, postpartum, and the first 8 years of life.

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*

Improvement Activities Implemented in 2020:

Antidepressant Medication Management—Effective Acute Phase Treatment

- QPAs provided educational flyer specifically on antidepressant medication adherence and educational flyer on PHQ-9 depression screening tool to all PCP offices.
- 'Ohana Health Plan has created a report to identify members in the acute phase sooner than what the current report provides. The health plan will be collaborating with its pharmacy vendor to help deliver medication to members' homes.

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

- QPAs provided educational flyer specifically on diabetes screening for members taking antipsychotic medication.
- 'Ohana Health Plan is reaching out to members for those diagnosed with schizophrenia needing diabetes screening by mail. The letter addresses the importance of continuing to take their antipsychotic medication as prescribed and an appointment agenda to bring with them at the next appointment with their PCP office to help member complete their annual screening for diabetes.

Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up

Improvement Activities Implemented in 2019:

- Complex Case Management (CCM) team connects members with their providers, appropriate care, and other needs after members are identified, including members that meet specific criteria, such as members with high ED utilizers (e.g., those treated for mental illness). Members are identified and outreached by the service coordination team through several areas of the health plan:
  - Lead Assessment Warehouse team notifies the SC team after member is identified to be a high acuity level through an assessment for chronic and comorbid conditions.
  - Triage nurses will send referral to the department when a notice from the emergency room (ER) or provider's office.
  - Intensive Care Nurse team notifies the SC team when members are visiting ER.
  - CCM team will conduct member outreach for assessment such as capturing the reasons for the multiple ER visits. CCM will also provide support on access to appropriate care and other member needs as identified through the assessment.
- Service Coordination Behavioral Health team runs a retrospective report to identify high ED utilizers then assigns members to case managers and community health worker (similar to peer support) to assist members with care planning, care coordination, housing, and assess them for Community Care Services (CCS) referrals in efforts to enroll members for appropriate care and coverage for their condition.
- At least quarterly, the Service Coordination Behavioral Health team and CCS collaborate with the following community partners in efforts to reduce high ED utilization:

  - Queen's Care Coalition—They are community navigators who support coordinating care for the members identified to be high ED utilizers of The Queen's Medical Center ED based on their criteria. They help members coordinate care in physical and behavioral health, and helps connect them with other community resources.
  - Waikiki Health (Wai Ola program)—They are an FQHC with a team of dedicated Community Health Workers and Case Managers who provide support for members identified as high ED utilizers based on their criteria.
- Service Coordination Behavioral Health team receives notifications on high ED utilizers from other referral sources (from Census, SC, UM, Quality, external referrals) and conducts outreach to these members to provide support and assistance.

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*

Improvement Activities Implemented in 2020:

- Hospital census data sent to select FQHCs: Analytical team and QPAs send weekly or bi-weekly census reports of admitted members for providers to provide care and to avoid hospital readmission.

CAHPS—Child Survey

2019 Recommendations

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 5-4 provides a summary of the key drivers identified for 'Ohana QI.

Table 5-4—'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	✓		✓

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
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.

Improvement Activities Implemented

To address areas of improvement related to access and timeliness and quality of care, the following improvement activities were implemented in 2020:

Provider Education

'Ohana Health Plan published newsletter articles in the provider newsletter to educate its providers on the following CAHPS-related topics:

- "Improving Patient Satisfaction and CAHPS Scores": Educates providers on CAHPS, describes what composites and overall ratings providers are scored on, and provides tips and best practices on how providers can improve the patient experience related to each composite/rating.
- "Shared Decision Making": Educates providers on the importance of shared decision making so they can work with their patients to make the best possible healthcare decisions for the patient.

In addition, a number of CAHPS-related educational materials used by the QPAs during provider visits were developed to educate providers on CAHPS, including how the survey is conducted, what questions may be asked of their patients, as well as activities providers can adopt to improve the overall patient experience. QPAs also educated on the importance of care coordination and reviewed 'Ohana's Health Services Referral form for members that may need service coordination or disease management services.

Member Education

'Ohana Health Plan published newsletter articles in the member newsletter to educate its members on the following CAHPS-related topics:

- "CAHPS stands for Consumer Assessment of Healthcare Providers and Systems": Educates members on the CAHPS survey, including what types of questions members are expected to answer if selected to participate.
- "Shared Decision Making": Educates members on what shared decision making is and the importance of working with their doctors to make decisions about their healthcare together.
- "Your Guide to Timely Care": Provides guidelines to members to help schedule their care, and informs members that doctors must provide urgent and routine care in a timely manner.
- "Transition of Care": Educates members on how 'Ohana Health Plan will support them with transition of care.
- "Always Talk to Your Doctor": Educates members on the importance of always talking with their healthcare providers about the care that is appropriate for them.

Access to Care

- 'Ohana Health Plan continues to utilize its 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. Agents continue to work directly with the member's PCP if the needed specialist is unavailable on the member's home island and 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.
- 'Ohana continues to work with providers to determine what support is needed to allow for opening of provider panels.

Customer Service

'Ohana Health Plan provided education to its customer service representative agents in 2020. Topics include but are not limited to the following:

- Customer Service Excellence.
- Cultivating Mental Agility.
- Building Resilience.
- Using the "Find a Provider Tool" to locate providers for members.
- Diversity and Inclusion Training.
- Redesigned call flow training on the contact management system to allow agents to assist members quickly and accurately, including improving caller experience by making hold times productive.
- Listening with Empathy.
- Customer Service Excellence and Listening to Customers.
- Customer Satisfaction Scores: What do they tell us and why they are important.
- What is a CAHPS Mock Survey and what is the purpose?: How to handle incoming calls from members regarding the CAHPS Mock Survey.
- Central Point Resources: Asking the right probing questions.
- What is CAHPS is why it is important to the Health Plan?

In addition, customer service satisfaction scores are reviewed every month. For low scoring calls, opportunities for improvement are identified, coaching and training are provided, and agents are placed on performance improvement plans when necessary. Awards are also provided to customer service representative agents who score the highest in quality, productivity, and meet service levels.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2019 NCQA HEDIS Compliance Audit Recommendations

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

- HSAG recommended that UHC CP QI improve its 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.

Improvement Activities Implemented

The following activities have been in place for 2019 and ongoing in 2020:

- UHC has a process to conduct internal audits of non-standard supplemental data sources to identify and proactively review data quality.
- At the time that UHC onboards a new structured data submitter, a project plan is completed, and screenshots from the EHR are captured.
- UHC reviews the NCQA technical specifications annually and, when warranted, adjusts the internal audit process to reflect the new requirements.

2019 HEDIS Performance Measure 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*

Improvement Activities Implemented

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—12–24 Months*, *25 Months–6 Years*, *7–11 Years*, and *12–19 Years*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total*
  - The 2020 UHCCP HI Member Handbook provides the time frames within which members can expect to get an appointment for primary care services, as well as for specialty and behavioral health services.
  - The Winter 2020 UHCCP HI Member Newsletter, *Health Talk*, has an article titled "A Healthy Start" that encourages all members of the family, adults and children, to schedule an annual well visit with their PCP. The article includes information if members need to find a new PCP.
  - The Spring 2020 edition of *Health Talk* has an article, "Your Partner in Health," that informs readers about the role of a PCP and when members should see one. The article also mentions the needs of teenaged members and how members can switch to a new PCP.
  - UHCCP HI is participating in an interactive voice recording (IVR) call campaign to members, in which targeted members receive an automated IVR to their home phone number. The recording is a call to action to complete a necessary visit, including an AAP visit, or screening, or for improved adherence to therapy.
  - Continuing in 2020 as part of the inbound Advocate4Me service delivery model, UHCCP customer service advocates (CSAs) assist members in scheduling urgent and non-urgent appointments and coordinating needed transportation services. Also, through the inbound Advocate4Me model, CSAs are alerted to members' open care opportunities and due screenings.
  - For the IET measure, Optum sent emails to 398 UHCCP behavioral health (BH) providers in Hawaii in March 2020. The email encouraged providers to schedule follow-up treatment for patients with a substance use disorder within 14 days of diagnosis, and it also provided suggestions for patient engagement and management and links to educational resources.
  - There have been discussions early in 2020 about incentivizing providers for the SBIRT (Screening, Brief Intervention and Referral to Treatment) performance measure, but further movement has been put on hold due to COVID-19. SBIRT could affect IET as SBIRT includes an assessment and a brief intervention or referral to an inpatient or outpatient facility if warranted, if a member is considered at risk for dependence.

Children's Preventive Health

- *Adolescent Well-Care Visits (AWC)*

- *Childhood Immunization Status (CIS)—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 (W34)*
  - In August 2020, the "Featured News" section on UHCprovider.com highlighted August as "National Immunization Awareness Month" with an article that provided links to resources on pediatric immunizations. Resources included tips, best practices, and parent-targeted handouts to support providers in engaging patients and guardians and completing needed immunizations. The article was also emailed to providers.
  - UHCCP HI is sending EPSDT member mailings to eligible members. The mailings include welcome and birthday postcards and delinquent notifications.
  - The EPSDT coordinator met with providers and shared information on the EPSDT program and visit and vaccination schedules.
  - UHCCP HI is participating in the 2020 Member Rewards Program (MRP). The MRP offers a sample of eligible members a $25 gift card for completing a care gap. AWC and W34 are included as incentivized HEDIS measures.
    - UHCCP HI quality clinical practice consultants (CPCs) shared with providers a list of their patients eligible for the MRP so that practices can reinforce the incentive when doing patient outreach.
    - UHCCP HI service coordinators (SCs) also received a list of their assigned members eligible for MRP so that they can highlight the MRP incentive and encourage visit completion.
  - UHCCP HI is also participating in the 2020 CP-PCPI (Community Plan—Primary Care Professional Incentive) program, which offers a financial incentive to providers for closing HEDIS care gaps with UHCCP HI members. AWC, CIS Combo 3, and W34 are incentivized measures in the CP-PCPi program.
  - Quality CPCs are currently collecting medical records for the CP-PCPi measures from provider offices and the Hawaii Health Information Exchange (HHIE).
  - Quality CPCs continue to support providers by educating them on UHCCP HI tools, reports, and programs that address pediatric and women's healthcare opportunities.
  - AWC was assigned to all Hawaii QUEST Integration managed care organizations as a required performance improvement project (PIP) topic. In April 2020, UHCCP HI began an intervention in collaboration with Waianae Coast Comprehensive Health Center (WCCHC). In this intervention, UHCCP HI CSAs reach out to members assigned to, but unestablished with, WCCHC and who are also due for an AWC visit. The intent is to improve WCCHC's AWC rate by either assisting unestablished members to schedule an AWC visit with WCCHC, or by removing members from WCCHC's patient panel if they have already established or would like to establish care with another PCP.
  - In 2020, the Quality CPC on Hawaii Island began planning discussions with Hui Mālama Ola Nā ʻŌiwi, a Native Hawaiian healthcare system on Hawaii Island, on a collaboration to provide well-child services in schools. Hui Mālama Ola Nā ʻŌiwi started working with a local

intermediate school and is willing to work with UHCCP HI on this initiative, but the initiative is currently on hold due to the COVID-19 pandemic.
    - The CPC informed providers on Hui Mālama Ola Nā ʻŌiwi's incentive of giving children in the community a sleeping bag for bringing in a completed immunization card, and also put UHCCP HI SC teams in touch with Hui Mālama Ola Nā ʻŌiwi's community health worker to share their community programs so that the SCs could inform their assigned members.
- The 2020 IVR call campaign includes voice recordings that address the AWC and W34 measures with targeted members.
- UHCCP HI is also doing EPSDT IVR calls in 2020, which are automated calls to targeted members/guardians that remind members ages 0 to 20 years to schedule their EPSDT visits. HEDIS measures impacted include W34, CIS Combo 3, AWC, and Immunizations for Adolescents (IMA).
- UHCCP is participating in the Pfizer Child Immunization Program that impacts the CIS measure. The program is sponsored by Pfizer and reminds parents of missed dose vaccines for children at ages six months, eight months, and 16 months through IVR calls and postcards. Reminders for a well visit during a child's first year are also included in the program.
- UHCCP HI Marketing and Disease Management are currently in planning discussions to implement virtual member education sessions. Topics planned include EPSDT program information.
- UHCCP HI Disease Management has developed an Annual Care Checklist specific to children's healthcare needs that reminds parents of important topics to discuss with their child's doctor. Well-child visits and immunizations are included topics. The Annual Care Checklist is also specific to the Hawaii market, as the Hawaiian word for "child/children" is used throughout. The checklist is currently awaiting State approval.
- In October 2020, the UHCCP HI clinical quality manager will conduct the annual inter-departmental quality training with the UHCCP HI Clinical Team. Training will include information on key HEDIS measures, including measures related to pediatric and women's health, as well as information on CAHPS.

Women's Health

- *Cervical Cancer Screening (CCS)*
- *Chlamydia Screening in Women—16–20 Years*, *21–24 Years*, and *Total*
    - The Women's Health email quality initiative had its annual launch to members in August 2020. The program's email was sent to eligible female members ages 18 and over to encourage them to complete recommended health screenings, including CCS. The email also included links that allowed members to search for a provider and contact UHCCP.
    - CCS is included in the 2020 MRP as an incentivized HEDIS measure.
    - CCS is also an incentivized measure in the 2020 CP-PCPi program.
    - Quality CPCs are currently collecting medical records for the CP-PCPi measures from provider offices and the HHIE.

- Quality CPCs continue to support providers by educating them on UHCCP HI tools, reports, and programs that address pediatric and women's healthcare opportunities.
- In October 2020, the UHCCP HI clinical quality manager will conduct the annual inter-departmental quality training with the UHCCP HI Clinical Team. Training will include information on key HEDIS measures, including measures related to pediatric and women's health, as well as information on CAHPS.
- The Optum LiveandWorkWell.com (LWW) website available to UHCCP HI members contains a video, "Why Get a Chlamydia Test?" that provides information on chlamydia and the importance of screening.
- The LWW website also has a guide titled, "Exposure to Sexually Transmitted Infections (STIs)" that provides general information on STIs and chlamydia.

Behavioral Health

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
  - In early Q3 2020, planning for a mail-out to both BH prescribers and PCPs began. Letters to BH providers were sent out on September 4, 2020, and informed providers of patients with both a schizophrenia or bipolar disorder diagnosis and prescribed antipsychotic medications who also have an open gap for metabolic screening. A similar mail-out was done in Q4 2019, but in 2020 planning was initiated earlier for an earlier mail-out target date to allow providers more time to engage patients and complete needed screenings.
  - In May 2020, Optum sent an email to 70 UHCCP BH providers in Hawaii that provided information on the connection between the medications prescribed for many psychiatric disorders, obesity, and type 2 diabetes. The email encouraged providers to ensure their patients on such medications receive HbA1c and LDL-C testing. Links to patient and provider educational resources were also provided in the email.

CAHPS—Child Survey

2019 Recommendations

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 5-5 provides a summary of the key drivers identified for UHC CP QI.

Table 5-5—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.		✓	
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.

Improvement Activities Implemented

Based on UHCCP HI's results on the 2019 CAHPS Child Survey, the following activities were implemented in 2020:

- The UHCCP HI CEO and Vice President of Network initiated planning in Q4 2019 for a letter and survey to be sent to pediatricians in 2020 to gather feedback on challenges and issues providers face that may impede member experience and impact scores on *Rating of Personal Doctor* and *Rating of Health Plan*.
  - Development of this initiative continued through Q1 and Q2 2020 and was included as an agenda item for UHCCP HI's Quality Management Committee (QMC) monthly meetings to give updates and get QMC members' feedback.
  - In July 2020, approximately 100 letters and surveys were mailed to pediatricians. UHCCP HI also included a $10 drugstore gift card in each letter as a small gesture of appreciation.
  - As of the end of August, UHCCP HI had received back about 40 responses.
  - The responses were shared and discussed at UHCCP HI's Quarter 3 Provider Advisory Committee (PAC) meeting on 08/19/2020 and at the 8/27/2020 QMC meeting. UHCCP HI will wait for more responses and then create a more formal report for additional PAC feedback and development of next steps.
- In Q3 2020, work began to update UHCCP HI's CAHPS Action Plan. The CAHPS Action Plan development includes creation of workgroups and/or updating existing workgroups to address areas of improvement identified through UHCCP HI's latest CAHPS results.
  - Efforts in 2020 include expanding the focus of the "How Well Doctors Communicate (HWDC)" workgroup to address *Personal doctor did not always spend enough time with member*, a key driver identified in the 2019 CAHPS Child Survey. UHCCP HI's PAC led the action planning to address HWDC in 2019 and continues to do so in 2020.
  - The "Health Plan Customer Service" workgroup's scope will look at the key drivers of *Receiving the information or help needed from customer service* and *Health plan forms were easy to fill out*.

  - To expand and ensure provider network adequacy, the "Getting Needed Care" workgroup continues development of a strategy to build relationships with pediatricians that includes provider education.
  - Members of the "Getting Needed Care" workgroup are also in a collaborative initiative with the other Hawaii QUEST Integration health plans to create member and provider educational materials on the use of telehealth. The intent is to facilitate members' ability to get the care, test, or treatments needed, as well as to increase access to specialists.
- The UHCCP HI 2020 Member Handbook includes the time frames within which members can expect to get appointments with their PCPs, including appointments for routine PCP visits for children, pediatric sick visits, and routine pediatric behavioral health visits.
- Starting in 2019 and continuing in 2020, UHCCP HI Customer Service (CS) Standard Operating Procedures (SOPs) were updated to include the appointment setting time frames so that CSAs are consistently aware of them and can educate members when speaking with them. The updated SOPs are "Advocate Outreach and Member Callback Process SOP" and "Advocate Proactive Member Engagement SOP."
- The UHCCP HI 2020 Member Handbook also states that UHCCP HI's Member Services department is available to assist members with filling out forms if needed. The Member Services telephone number, hours of operation, and policy for returning after-hours calls are provided.
- For members or guardians of pediatric members who feel that their doctor or child's doctor did not spend enough time with them and/or talk to them about specific things to do to prevent illness, the Spring 2020 Member Newsletter, *Health Talk*, included a "Check It Off" article that listed in checklist format recommended topics for members to discuss with PCPs, with the intent to help members get the most out of their visit. The article also included space for members to write down their own questions to prepare for the PCP visit.
- UHCCP HI will be printing 5,000 copies of the "Check It Off" checklist for the SCs to distribute to members as a leave-behind flyer (targeting fall 2020).
- UHCCP HI Disease Management has developed an Annual Care Checklist specific to children's healthcare needs that reminds parents of important topics to discuss with their child's doctor. The checklist advises parents to discuss getting needed care for their children, such as care for tests or treatment, routine or urgent care appointments, coordination with specialists, and prescription drug issues. The Annual Care Checklist is also specific to the Hawaii market and the Hawaiian word for "child/children" is used throughout. The checklist is currently being vetted for final approval within UHCCP HI; once approved internally, the checklist will be submitted for the State approval process.
- In June 2020, the "Featured News" section on UHCprovider.com featured an article on care coordination and its importance. The article lists patient engagement strategies that can help providers improve care coordination with other providers; these strategies can also apply to parents or guardians of pediatric patients. The article also provided a link to UHCCareConnect, an online tool to support providers with care coordination and other patient care opportunities.
- In August 2020, the "Featured News" section on UHCprovider.com highlighted August as "National Immunization Awareness Month" with an article that provides links to resources on pediatric immunizations. Resources include tips, best practices, and parent-targeted handouts to support

providers in engaging patients and guardians and addressing their concerns. The article was also emailed to providers.

- In September 2020, the UHCCP HI quality CPC on Hawaii Island met separately with two FQHC. At each meeting, the CPC reviewed UHCCP HI's results of the 2019 CAHPS Child Survey and the identified areas for improvement. The CPC and each FQHC team discussed how workflows could be improved to address the areas and incorporating pediatric-specific questions into their own practice surveys for their patients.
- UHCprovider.com has a link to a document titled, "Checklist to Help Improve CAHPS and HOS Survey Results." The checklist gives providers ideas on how to discuss key topics with their patients to help improve their experience, and the ideas also apply to speaking to parents and guardians of pediatric patients.
- UHCCP HI Marketing and Disease Management are currently in planning discussions to implement virtual member education sessions. Topics planned include how members can contact UHCCP HI with questions and how to register for myuhc.com.
- In October 2020, the UHCCP HI clinical quality manager will conduct the annual inter-departmental quality training with the UHCCP HI Clinical Team. Training will include information on key HEDIS measures, including measures related to pediatric and women's health, as well as information on CAHPS.
- UHCCP HI developed and piloted a questionnaire for use at quarterly UHCCP HI Member Advisory Group (MAG) meetings, with the intent to gather members' feedback on their experiences with UHCCP HI and network providers. The questionnaire was first used in 2019, and UHCCP HI plans to continue its use at future MAG meetings and to continually update its questions based the health plan's latest CAHPS results.

'Ohana Community Care Services ('Ohana CCS)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2019 NCQA HEDIS Compliance Audit Recommendations

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.

Improvement Activities Implemented

Centene and 'Ohana's HEDIS 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 in advance impact reports on each source in order to identify measures that would be affected by each supplemental data source.

2019 HEDIS Performance Measure 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*

Improvement Activities Implemented

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

Improvement Activities Implemented in 2020:

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
  - The provider educational flyer was created by an enterprise-wide IET workgroup that 'Ohana Health Plan took part in, in late 2019. The flyer was approved for 'Ohana Health Plan in 2020.
  - CCS team plans to educate community-based case management (CBCM) agencies specifically on the IET measure and have them communicate with member's PCP on not diagnosing them, rather referring member to their BH provider to rule out the possibility of SUD. If this intervention does not show positive results, the next phase will be to assess the program to include the measure as part of their incentive program such as scorecard. Finally, if the incentive results as ineffective intervention, health plan will reassess for a new improvement plan.
- *Antidepressant Medication Management—Effective Acute Phase Treatment*

  - In Q1 2020, the CCS team in collaboration with CBCM agencies piloted an intervention on starting a dialogue with members who are taking antidepressant on medication adherence. Although the list was small due to the report constraint, the test run was completed.
  - From the pilot conducted with CBCM agencies, the health plan identified that the care gap list generally produced and utilized for most HEDIS interventions will not suffice as the health plan will miss the opportunity to have CBCM agencies reach out to most of the members by the time members are identified on the monthly report. The Pharmacy, Quality and Data Analyst teams are in the process of creating a timely report and once completed, the health plan will team up with 5 Minute Pharmacy, a Pharmacy vendor, to help deliver members' medication as well as re-launch the intervention with CBCM agencies in increasing engagement in medication adherence for members on antidepressants.
  - CCS and Pharmacy teams leveraged an existing partnership with 5 Minute Pharmacy, a pharmacy vendor that delivers medication per request by members to their homes.
- *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*
  - PIP intervention project launched, in August, for follow-up post-ED visit for mental illness and it is in testing period until the end of the year. Piloting the intervention with two (2) CBCM agencies.
  - The two CBCMs involved in PIP intervention began receiving non-mental illness ED visit notifications to assist with outreaching members to provide support as needed post-ED visit.
  - CCS holds regular IDTs (Interdisciplinary Team Meetings) for the high ER utilizers. Present in those meeting is 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.
  - The CCS team works with the Queen's Care Coalition for the high ER utilizers, meeting monthly to discuss treatment plans for the individual members identified as high ER utilizers at The Queen's Medical Center.
  - If the high ER utilizer is an 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 an ER visit.
  - The CCS team launched a quality initiative in efforts to improve adherence for antipsychotic medication with the judicious use of long-acting injectables LAIs in members non-adherent or treatment resistant with oral antipsychotics. The CCS team is partnering with the Quality and Pharmacy teams to drive this initiative through engagement of CBCMs, prescribers, and 5 Minute Pharmacy. Adherence to antipsychotic medication is highly correlated with the reduction of utilization in ED visits as well as hospitalization.[5-1]

[5-1] Wander, Curtis. "Schizophrenia: Opportunities to Improve Outcomes and Reduce Economic Burden Through Managed Care." *American Journal of Managed Care*, April 12, 2020. Available at: https://www.ajmc.com/view/schizophrenia-opportunities-to-improve-outcomes-and-reduce-economic-burden-through-managed-care. Accessed on: Dec 11, 2020.

- The CCS and Pharmacy teams partner with 5 Minute Pharmacy and Medipharm on improving medication adherence for psychotropics via their mobile pharmacy services to deliver medication to where member is residing.

Appendix A. Methodologies for Conducting EQR Activities

Introduction

In CY 2020, 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 2019 CAPs
- Validation of performance measures (i.e., NCQA HEDIS Compliance Audits)
- Validation of PIPs
- A survey of adult 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 2020, 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

2020 Compliance Monitoring Review

Objectives

The Balanced Budget Act of 1997 (BBA), as set forth in 42 CFR §438.358, requires that a state or its designee conduct a review to determine each MCO's and PIHP's compliance with federal managed care regulations and state standards. Oversight activities must focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries by the MCO/PIHP. To complete this requirement, HSAG—through its EQRO contract with the MQD—conducted a compliance evaluation of the health plans and the CCS program health plan. For the 2020 EQR compliance monitoring activity, the second year of the MQD's three-year cycle of compliance review activities, HSAG conducted a desk audit and a virtual 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 2020 review was to provide meaningful information to the MQD and the QI and CCS health plans regarding contract compliance with those standards.

The following eight standards were assessed for compliance:

- Standard I Provider Selection
- Standard II Subcontractual Relationships and Delegation
- Standard III Credentialing
- Standard IV Quality Assessment and Performance Improvement
- Standard V Health Information Systems
- Standard VI Practice Guidelines
- Standard VII Program Integrity
- Standard VIII Enrollment and Disenrollment

The findings from the desk audit and the virtual 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 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 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[A-1]

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Apr 21, 2020.

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; provider contract templates; and executed subcontractor agreements. For the record reviews conducted, HSAG generated audit samples based on data files that the health plan provided (i.e., listings of credentialed and recredentialed providers within the review period). HSAG also obtained information for the compliance monitoring review through observation during the virtual 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 2020 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 and Risk-Adjusted Utilization			
Adults' Access to Preventive/Ambulatory Health Services	✓		Admin
Ambulatory Care—Total (per 1,000 Member Months)		✓	Hybrid
Hospitalization for Potentially Preventable Complications	✓		Admin
Initiation and Engagement of AOD Abuse or Dependence Treatment		✓	Admin
Plan All-Cause Readmissions	✓		Admin

Performance Measure	QI	CCS	Methodology
Children's Preventive Health			
Adolescent Well-Care Visits	✓		Hybrid
Childhood Immunization Status	✓		Hybrid
Immunizations for 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
Prenatal and Postpartum Care	✓		Hybrid
Care for Chronic Conditions			
Comprehensive Diabetes Care	✓		Hybrid
COPD or Asthma in Older Adults Admission Rate	✓		Admin
Heart Failure Admission Rate	✓		Admin
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		✓	Admin
Antidepressant Medication Management		✓	Admin
*Behavioral Health Assessment***		✓	Hybrid
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		✓	Admin
Follow-Up After Emergency Department Visit for Mental Illness		✓	Admin
Follow-Up After Hospitalization for Mental Illness	✓	✓	Admin
Follow-Up Care for Children Prescribed ADHD Medication	✓		Admin
*Screening, Brief Intervention, and Referral to Treatment***	✓		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.

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 2020, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*. The measurement period reviewed for the health plans was CY 2019 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. a. For Effectiveness of Care (EOC) and EOC-like measures, when the denominator is <30. b. For utilization measures that count member months, when the denominator is <360 member months. c. For all risk-adjusted utilization measures, when the denominator is <150. d. For electronic clinical data systems measures, when the denominator is <30.
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 2020, 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 2019 and to the previous year's rates, where applicable. Measure rates reported by the health plans, but not audited by HSAG in 2020, are not presented within this report. Additionally, certain measures do not have applicable benchmarks. For these reasons, the HEDIS 2019 rate, relative difference, and 2020 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:

★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile
★★ = 25th percentile to 49th percentile
★ = Below the 25th percentile

Rates shaded yellow indicate that the rate met or exceeded the MQD Quality Strategy target for HEDIS 2020. 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*

Measure	MQD Quality Strategy Target[1]
Women's Health	
Breast Cancer Screening	75th Percentile
Cervical Cancer Screening	75th Percentile
Prenatal and Postpartum Care—Timeliness of Prenatal Care[2]	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
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

[1] The MQD Quality Strategy targets are based on NCQA's HEDIS Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2019.
[2] Due to changes in the technical specifications for this measure in HEDIS 2020, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, comparisons to benchmarks (i.e., the MQD Quality Strategy target) were not performed for this measure.

For the following measure, a lower rate indicates better performance: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%).*

Validation of Performance Improvement Projects

Objectives

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine each health plan's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Technical Methods of Data Collection and Analysis

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[A-2]

Over time, HSAG and some of its contracted states identified that, while the health plans have designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few health plans achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement.[A-3] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects health plans to focus on small tests of change in order to determine what interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the CMS PIP protocol. HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that given the pace of quality improvement science development and the prolific use of PDSA cycles in modern improvement projects within healthcare settings, a new approach was needed.

The key concepts of the new PIP framework include forming a PIP team, setting aims, establishing a measure, determining interventions, testing interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the PIP to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is 18 months.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov 5, 2020.

[A-3] For more information about the Associates in Process Improvement's Model for Improvement, go to: http://www.ihi.org/education/IHIOpenSchool/resources/Pages/BobLloydWhiteboard.aspx#MFI to view the video, The Model for Improvement.

For this PIP framework, HSAG developed five modules with an accompanying reference guide. HSAG conducts webinar trainings prior to each module submission and Module 4 progress check-ins while health plans are testing interventions. HSAG also provides written feedback after each module is validated and offers technical assistance to provide further guidance. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, FMEA, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** In Module 4, the interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the MCO summarizes key findings and outcomes, presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

Upon completion of a 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.

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 initiated new PIPs and began the validation process by submitting Modules 1 and 2. Subsequently in 2020, the health plans continued with the PIPs, progressed through Module 3 and started intervention testing in Module 4. The health plans had not yet progressed to reporting PIP outcomes.

The PIP topics are included in Table A-4.

Table A-4—Continued PIP Topics in 2020 (Module 1 through Module 3 and Intervention testing)

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*

2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

The primary objective of the Adult Medicaid CAHPS survey was to effectively and efficiently obtain information on the levels of experience of the Hawaii Medicaid adult members with their health plan and healthcare services. Results were provided at both plan-specific and statewide aggregate levels.

The primary objective of the CHIP CAHPS survey was to obtain experience information from the Hawaii CHIP population to provide to the MQD and to meet the State's obligation for CHIP CAHPS measure reporting to CMS. Results were provided to the MQD in a statewide aggregate report.

Technical Methods of Data Collection and Analysis

Data collection for the Adult CAHPS survey and the CHIP CAHPS survey was accomplished through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult members of the QI health plans, and the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the CCC measurement set) to CHIP members. Adult members included as eligible for

the survey were 18 years of age or older as of December 31, 2019. CHIP members included as eligible for the survey were 17 years of age or younger as of December 31, 2019. All members (or parents/caretakers of sampled CHIP members) completed the surveys from February to May 2020 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 cover letters provided with the English version of the CAHPS survey questionnaire included additional text in Chinese, Ilocano, Korean, and Vietnamese informing members (or parents/caretakers of sampled members) that they could call a toll-free number to request to complete the survey in one of these designated alternate languages. The toll-free line for alternate survey language requests directed callers to select their preferred language for completing the survey and leave a voice message for an interpreter service that would return their call and subsequently schedule an appointment to complete the survey via computer-assisted telephone interviewing (CATI). A reminder postcard was sent to all non-respondents, followed by a second survey mailing, a second reminder postcard, and a third survey mailing.[A-4] It is important to note that the CAHPS 5.0H Health Plan Surveys are made available by NCQA in English, Spanish, and Chinese (adult survey via mail) only.[A-5] 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 adult members the option to complete the CAHPS survey in the designated alternate languages.[A-6]

The Adult CAHPS survey included a set of standardized items (40 questions) that assessed members' perspectives on their care. The CHIP CAHPS survey included a set of standardized items (41 questions) that assessed parents'/caretakers' perspectives on their child's care. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed to select the adult and CHIP members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. An analysis of the CAHPS 5.0H Adult Survey and the CAHPS 5.0 Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures. NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS survey result; however, for this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

[A-4] The telephone phase of the survey field was not implemented for non-respondents as scheduled due to guidelines outlined by President Trump's declaration of a national emergency in response to the COVID-19 pandemic in the United States in March 2020.

[A-5] Administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.0H Adult Medicaid Health Plan Survey is made available by NCQA in English, Spanish, and Chinese only. The standard Chinese translation for the adult Medicaid CAHPS survey can only be used for the mail survey protocol. 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.

[A-6] National Committee for Quality Assurance. *HEDIS® 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2019.

The survey questions were categorized into nine measures of experience. These measures included four global rating questions, four composite measures, and one individual item measure. The global measures (also referred to as global ratings) reflect 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 measure is an individual question that considers a specific area of care (i.e., *Coordination of Care*).

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 four composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite and individual item measure questions' response choices were: (1) "Never," "Sometimes," "Usually," and "Always." A positive or top-box response for the composite measures and individual item measure was defined as a response of "Usually/Always." The final composite measure score was determined by calculating the average score across all questions within the composite measure (i.e., mean of the composite items' top-box scores).

For each CAHPS measure, the resulting top-box scores were compared to NCQA's 2019 Quality Compass Benchmark and Compare Quality Data.[A-7] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each measure, with one being the lowest possible rating and five being the highest possible rating, using the following percentile distributions shown in Table A-5:

Table A-5—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

Additionally, HSAG performed a trend analysis of the adult Medicaid and CHIP results. The CHIP 2020 scores were compared to their corresponding 2019 scores to determine whether there were statistically significant differences. The adult Medicaid 2020 scores were compared to their corresponding 2018 scores to determine whether there were statistically significant differences.[A-8] Lastly, the adult Medicaid QI health plans' and the QI Program aggregate's 2020 scores were compared to the 2019 NCQA adult

[A-7] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

[A-8] HSAG did not survey the adult Medicaid population in 2019.

Medicaid national averages, and CHIP's 2020 scores were compared to the 2019 NCQA child Medicaid national averages.[A-9] These comparisons were performed for the four global ratings, four composite measures, and one individual item measure.

Also, HSAG performed a key drivers of member experience analysis of the adult Medicaid and CHIP populations 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, the key drivers of member experience analysis helps decision makers identify specific aspects of care that will most benefit from quality improvement activities. The analysis provides information on:

- How ***well*** the health plan/program is performing on the survey item.
- How ***important*** that item is to overall member experience.

Description of Data Obtained

The CAHPS survey asks members or parents/caretakers to report on and to evaluate their/their child's experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The surveys were administered from February to May 2020 and were designed to achieve the highest possible response rate. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the designated five questions were completed.[A-10] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), had a language barrier, or were mentally or physically incapacitated (adult Medicaid only). Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the Adult CAHPS surveys, HSAG provided the MQD with a plan-specific report of findings and a statewide aggregate report. The MQD also received a statewide aggregate report of the CHIP survey results.

The plan-specific results of the Adult CAHPS survey are summarized in Section 3 and the CHIP results of the Child CAHPS survey are summarized in Section 1 of this report. A statewide comparison of each

[A-9] NCQA national averages for the child Medicaid population were used for comparative purposes, since NCQA does not provide separate benchmarking data for the CHIP population. Therefore, caution should be exercised when interpreting these results.

[A-10] A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for adult Medicaid: questions 3, 10, 19, 23, and 28. A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for CHIP: questions 3, 10, 22, 26, and 31.

adult Medicaid QI health plan and the QI Program aggregate results, as well as the CHIP population results, are provided in Section 4.

Encounter Data Validation

Objective

Accurate and complete encounter data are critical to the success of any managed care program. In CY 2020, the MQD is evaluating the possibility of using its internal encounter data systems to support its rate setting activities instead of relying on the health plan submitted data files. As such, in order to ensure that the Medicaid reimbursement rates are based on complete and accurate data, the MQD contracted HSAG to conduct a validation of its encounter data. The study focuses on three evaluation activities:

- Targeted encounter data IS assessment
- Gap analysis and best practice recommendations for data quality assessment
- Administrative profile—assessment of encounter data accuracy, completeness, and timeliness

Together these different activities will provide a comprehensive picture of the MQD's encounter data, factors affecting completeness and accuracy, and general confidence in the use of its encounter data for rate setting purposes.

Technical Methods of Data Collection and Analysis

Targeted Encounter Data IS Assessment

The targeted encounter data IS assessment was designed to define how each participant in the encounter data process collects and processes encounter data such that the flow of the data from the MCOs' vendors to the MCOs and from the MCOs to the MQD is understood. The IS review is key to understanding whether the IS infrastructures in place are likely to produce complete and accurate encounter data.

The assessment component of the encounter data validation activity consisted of a three-stage process:

- **Document review**: HSAG conducted a thorough desk review of documents related to current encounter data initiatives/validation activities. HSAG used documents such as policies and procedures, encounter system edits, and the MQD's current encounter data submission requirements to develop a targeted questionnaire designed to address specific topics of interest for the MQD.
- **Development and fielding of customized encounter data assessment**: In collaboration with the MQD, HSAG developed a targeted IS questionnaire, designed to gather both general and specific information regarding data processing, personnel, and data acquisition capabilities for the MQD and

the MCOs to complete. The questionnaire included assessment items grouped into the following five topic areas:

- Encounter Data Sources and Systems
- Data Exchange Policies and Procedures
- Management of Encounter Data: Collection, Storage, and Processing
- Encounter Data Quality Monitoring and Reporting
- Rate File Encounter Data Extract

- **Key informant follow-up**: Upon completion of the customized encounter data assessment, HSAG followed up with key personnel at the MQD and the MCOs to clarify any information provided through questionnaire responses.

Gap Analysis and Best Practice Recommendations

The gap analysis will seek to understand what reports the MQD currently receives and identify any potential modifications necessary to elevate their comprehensiveness in assessing data quality. Additionally, the gap analysis will also review additional pre-built reporting templates available to the MQD that have not previously been deployed that would augment the comprehensiveness of data quality monitoring tools available to the MQD and identify any necessary modifications to the pre-built template.

Based on this analysis HSAG will identify and present a series of actionable recommendations to the MQD on (a) modifications to current reports received by the MQD; (b) implementation of pre-built reports available to the MQD along with any suggested modifications; and (c) new reports necessary to comprehensively implement a data quality program for the MQD based on best practice recommendations. HSAG will also synthesize the information gained from the targeted encounter data IS assessment and the administrative profile activities to develop actionable recommendations that the MQD may consider when developing future encounter data activities.

Administrative Profile

To examine the accuracy, completeness, and timeliness of the MQD's encounter data, HSAG will assess encounter data with service dates between January 1, 2019, and December 31, 2019, based on the following metrics:

- Metrics for encounter data completeness
  - Monthly encounter record counts by Medicaid Management Information System (MMIS) month (i.e., the month when encounters are processed by MMIS)
  - Monthly encounter volume by service month (i.e., the month when services occur)
  - Monthly encounter volume per 1,000 member months by service month
  - Monthly paid amount per 1,000 member months by service month
- Metrics for encounter data timeliness

  - Claims lag triangle to illustrate the percentage of encounters accepted into the MMIS within two months, three months, …, and such from the service month
  - Percentage of encounters processed by MMIS within 30 days, 60 days, 90 days, …, and such from the payment date
- Metrics for field-level encounter data completeness and accuracy
  - Percent present and percent with valid values for selected key data elements
- Encounter Data Referential Integrity
  - Identify that the encounter data can be merged with and contained the appropriate provider and member in the provider and member enrollment files, respectively
- Encounter Data Logic
  - Based on the likely use of the encounter data in future analytic activities (e.g., performance measure development/calculation), develop logic-based checks to ensure the encounter data appropriately support the activities. For example, develop a logic-based metric that evaluates that type of bill is appropriately captured on facility claims

Depending on the needs identified by the MQD, all analyses can be stratified by geography (e.g., by island), Form Type, major Provider Type, and Service Type to provide additional comparative information. Other methods include a cross-sectional or longitudinal comparison of utilization measures and discrepancy analyses of age- and gender-specific diagnoses and procedures (e.g., male members with an encounter for pregnancy).

Description of Data Obtained

The administrative profile component of the CY 2020 encounter data validation study will use numerous data sources including encounter data, member demographic/enrollment data, and provider data. Based on the study objectives and data elements to be evaluated in this study, HSAG submitted a data submission requirements document to notify the MQD of the required data. The data submission requirements included a brief description of the study, the review period, required data elements, and information regarding the submission of the requested files.

After reviewing the data submission requirements document, the MQD extracted the requested data from its MMIS and submitted them to HSAG between July and October of 2020, for the administrative profile analysis. The administrative profile analysis will examine the accuracy, completeness, and timeliness of the MQD's encounter data with service dates between January 1, 2019, and December 31, 2019.