State of Hawaii

Department of Human Services

Med-QUEST Division

2021 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

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HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Overview

The 2021 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 and Children's Health Insurance Program (CHIP) 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 (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 with revisions released (or as amended) November 13, 2020, 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: Dec 10, 2021.

This report provides:

- An overview of the QI and CCS programs.
- A description of the scope of EQR activities performed by HSAG and the manner in which the data from these activities were analyzed and aggregated, and conclusions were drawn.
- 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, provider survey, and results of an encounter data validation (EDV) study.
- Recommendations for the health plans to improve member access to care, quality of care, and timeliness of care.
- Recommendations on how the State can target goals and objectives in the quality strategy to better support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid beneficiaries.
- A comparative analysis of health plan performance.
- An assessment of the degree to which each health plan addressed recommendations for quality improvement made by HSAG during the previous year's EQR.

Scope of EQR Activities

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

- *Review of compliance with federal and state-specified operational standards*. HSAG conducted follow-up reviews of the health plans that were required to take corrective actions related to findings from HSAG's 2020 compliance review.
- *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 *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[1-3] 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 2021, the health plans concluded the rapid-cycle PIP topics that began in 2019 and were in discussion with the MQD regarding the selection of new PIP topics.

[1-3] 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/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 22, 2021.

- *Validation of performance measures*. HSAG validated each health plan's performance measure results for a set of Healthcare Effectiveness Data and Information Set (HEDIS)®[1-4] and non-HEDIS performance measures selected by the MQD to evaluate the accuracy and reliability of the health plans' data that contributed to the performance measure rate calculations. HSAG assessed the performance measure results and their impact on improving the health outcomes of members. HSAG conducted validation of the performance measure rates following the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™[1-5] guidelines and timeline, which occurred from January 2021 through July 2021. The final audited performance measure validation results for each health plan reflected the measurement period of January 1, 2020, through December 31, 2020. HSAG provided final audit reports to the health plans and the MQD in July 2021.
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys*.[1-6] The MQD conducted CAHPS surveys of the child QI health plans and Children's Health Insurance Program (CHIP) populations to learn more about members' experiences with care. The standardized survey instrument administered to parents/caretakers of child Medicaid members of the QI health plans and parents/caretakers of child members enrolled in CHIP was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with chronic conditions [CCC] measurement set). All parents/caretakers of sampled child members completed the surveys from February to May 2021. HSAG aggregated and produced final reports in September 2021.
- *Provider Survey*. The MQD conducted surveys to healthcare providers who serve QI members through one or more QI health plans to learn more about providers' perceptions of the QI health plans. HSAG and the MQD developed a survey instrument designed to acquire provider information and gain providers' insight into the QI health plans' performance and potential areas of performance improvement. Providers completed the surveys from July to September 2021. HSAG aggregated and produced a final report in December 2021.
- *Encounter data validation.* HSAG and the MQD initiated an EDV study in early 2020. The study focused 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 the MQD's rate setting activities. The three activities included were (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 aggregated and produced a final report in May 2021.

Overall Summary of Health Plan Performance

Compliance Monitoring Review

For the 2021 reevaluation of health plan compliance, HSAG used a monitoring tool to assess and document the health plans' implementation of corrective actions in any standards where deficiencies had

[1-4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-5] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
[1-6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

been identified during the 2020 review. The standards were related to select health plan requirements, as described in the managed care regulations at 42 CFR §438.

Findings, Conclusions, and Recommendations

Table 1-1 illustrates each plan's individual performance on resolving its corrective action plan (CAP) areas and a statewide total for the six plans overall.

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

Standard Name		AlohaCare QI	HMSA QI	KHFP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Total # CAPs per Standard
I.	Provider Selection	1/1	NA	1/1	NA	NA	NA	**2/2**
II.	Subcontracts and Delegation	1/1	NA	6/6	1/1	NA	1/1	**9/9**
III.	Credentialing	NA	1/1	1/1	NA	NA	NA	**2/2**
IV.	Quality Assessment and Performance Improvement	NA	NA	NA	NA	NA	N/A	**NA**
V.	Health Information Systems	NA	NA	NA	NA	NA	NA	**NA**
VI.	Practice Guidelines	NA	NA	NA	NA	NA	NA	**NA**
VII.	Program Integrity	NA	1/1	2/2	NA	2/2	NA	**5/5**
VIII.	Enrollment and Disenrollment	NA	NA	NA	NA	NA	NA	**NA**
	Total # CAPs and Resolved CAPs by Health Plan:	**2/2**	**2/2**	**10/10**	**1/1**	**2/2**	**1/1**	**18/18**

Numerator = # of CAPs "closed" and found compliant during follow-up review.
Denominator = Total # of CAPs required for the standard following the prior year (2020) compliance review.
NA = Not Applicable. Reevaluation was not necessary as the health plan achieved 100 percent for the standard.

The QI health plans' CAP implementation resulting from HSAG's 2020 compliance review was monitored by HSAG and the MQD. Following completion of its CAPs, each plan submitted documentation for HSAG's desk review to ensure that the deficiencies were resolved and that compliance was attained. As needed, health plans were provided additional technical assistance and monitoring until compliant with each standard. The results of each reevaluation were provided to the plan and the MQD as a record of how the deficiencies were addressed. All five QI health plans and CCS completed the CAPs in 2021.

Calendar year (CY) 2022 will begin a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the *HEDIS Measurement Year (MY) 2020 Volume 5, HEDIS*

Compliance Audit: Standards, Policies and Procedures.[1-7] The audit procedures were also consistent with the CMS protocol for performance measure validation (PMV): *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[1-8] The health plans that contracted with the MQD during MY 2020 for the 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 performance measure data, including a review of the specific data collection methodologies used to report the required performance measures. The NCQA HEDIS Compliance Audit for the CCS program evaluated IS capabilities in reporting a set of HEDIS and non-HEDIS performance measures relevant to behavioral health. The measurement period was CY 2020 (January 1, 2020, through December 31, 2020), and the audit activities were conducted concurrently with HEDIS MY 2020 reporting.

For MY 2020 reporting, the State selected a set of performance measures from NCQA's *HEDIS Measurement Year 2020 & Measurement Year 2021 Volume 2: Technical Specifications for Health Plans;* CMS' *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting;* and CMS' *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set), Technical Specifications and Resource Manual for Federal Fiscal Year 2021 Reporting*. For measures that were both HEDIS and Core Set, health plans were required to follow NCQA's *HEDIS Measurement Year 2020 & Measurement Year 2021 Volume 2: Technical Specifications for Health Plans* and report any additional age stratifications required by the *Adult Core Set* and *Child Core Set.* The health plans were required to report on 12 measures, yielding a total of 59 measure indicators, for the QI population. 'Ohana CCS was required to report on nine measures, yielding a total of 42 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-Adjusted 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 and CCS health plan's measure data collection and reporting processes to determine compliance with NCQA's IS standards during the MY 2020 NCQA HEDIS Compliance Audits. HSAG determined all QI health plans to be *fully compliant* with all NCQA HEDIS IS standards.

[1-7] National Committee for Quality Assurance. *HEDIS Measurement Year 2020 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.* Washington, DC: NCQA; 2020.
[1-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 7, 2021.

Overall, the health plans followed the measure specifications required by the State to calculate the required HEDIS and non-HEDIS performance measure rates, and all measures received the audit designation of *Reportable*.

Performance Measure Results

HSAG analyzed the HEDIS MY 2020 performance measure results for each health plan, and where applicable, HSAG compared the results to NCQA's Quality Compass®[1-9] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2019 (referred to throughout this report as percentiles). For three measure indicators where a lower rate indicates better performance (i.e., *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total, Comprehensive Diabetes Care—HbA1c Poor Control [>9%],* and *Ambulatory Care—Emergency Department Visits—Total)*, HSAG reversed the order of the benchmarks for performance level evaluation to be consistently applied.[1-10]

Additionally, HSAG analyzed the results for one performance measure developed by the MQD (i.e., *Behavioral Health Assessment*), four CMS *Adult Core Set* measures, and one CMS *Child Core Set* measure. Of note, these measures do not have applicable benchmarks for comparison.

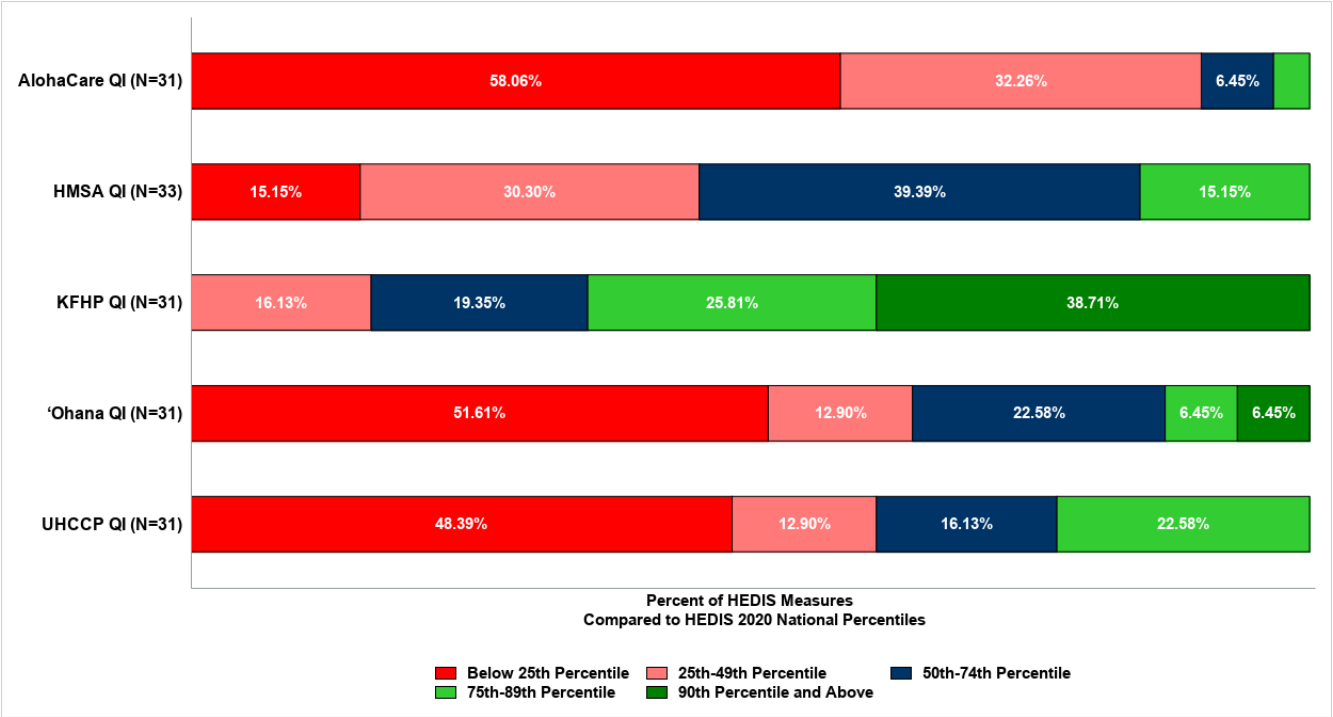
In the following figures, "N" indicates, by health plan, the total number of performance measure indicators that were compared to the benchmarks for QI and CCS. Rates for which comparisons to benchmarks were not appropriate or rates that were not reportable (e.g., *Small Denominator*, *Biased Rate*)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

Figure 1-1 displays the QI health plans' HEDIS MY 2020 performance compared to benchmarks, where applicable. HSAG analyzed results from 12 performance measures for HEDIS MY 2020 (a total of 59 indicator rates), of which 35 indicators were comparable to benchmarks. Of note, all the health plans had at least one measure indicator receive a status of *NA* (i.e., *Small Denominator*).

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

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

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



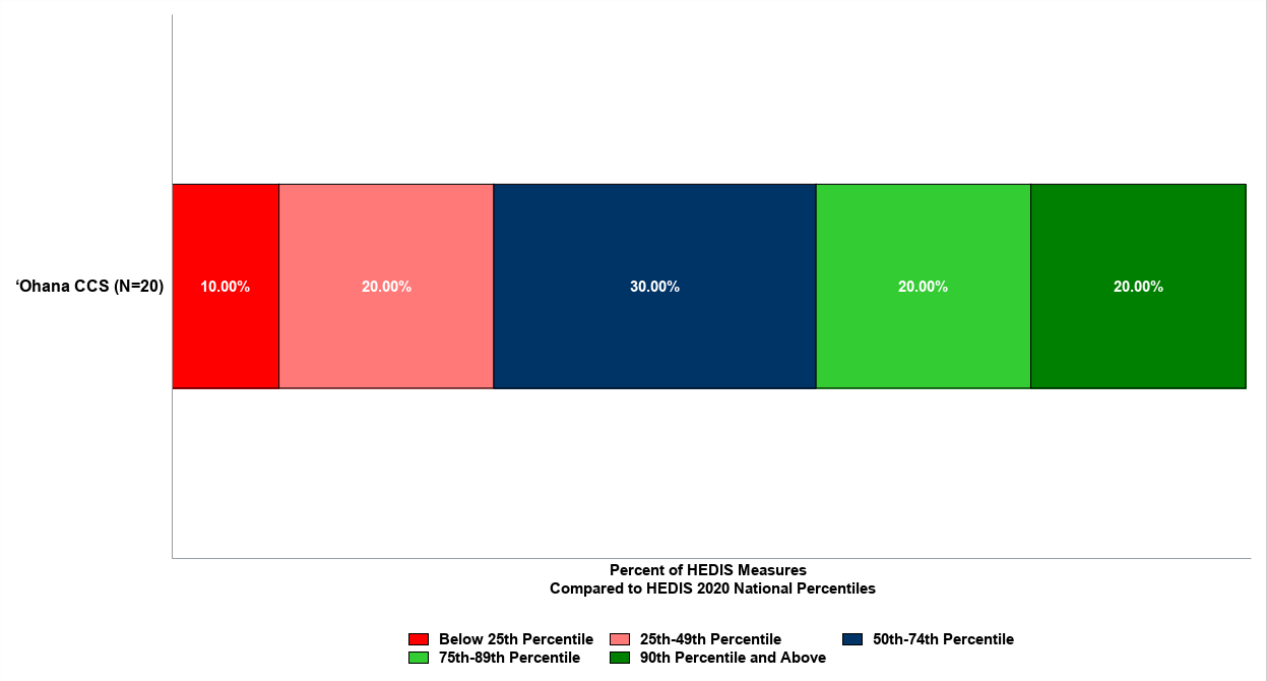
As presented in Figure 1-1, KFHP QI was the highest-performing plan for HEDIS MY 2020, with 26 of 31 (83.9 percent) measure rates ranking at or above the 50th percentile, including 12 rates (38.7 percent) meeting or exceeding the 90th percentile. HMSA QI was the second-highest-performing health plan, with 18 of 33 (54.5 percent) measure rates ranking at or above the 50th percentile, including five rates (15.2 percent) ranking at or above the 75th percentile. For UHC CP QI, 12 of 31 (38.7 percent) measure rates ranked at or above the 50th percentile, with seven rates (22.6 percent) ranking at or above the 75th percentile.

Conversely, AlohaCare QI and 'Ohana QI fell below the 50th percentile for 28 of 31 (90.3 percent) and 20 of 31 (64.5 percent) measure rates, respectively, indicating opportunities for improvement. Further, 18 of AlohaCare QI's 31 measure rates (58.1 percent), 16 of 'Ohana QI's 31 measure rates (51.6 percent), and 15 of UHC CP QI's 31 measure rates (48.4 percent) fell below the 25th percentile. Of note, 'Ohana QI had two measure rates that met or exceeded the 90th percentile.

Additionally, eight of 12 measures with MQD Quality Strategy targets were comparable to benchmarks for HEDIS MY 2020. HMSA QI and UHC CP QI demonstrated positive performance, meeting eight of 12 (66.7 percent) targets, while KFHP QI met seven of 12 (58.3 percent) targets. Conversely, AlohaCare QI and 'Ohana QI demonstrated opportunities to improve care overall; AlohaCare QI met two of 12 (16.7 percent) targets, and 'Ohana QI met five of 12 (41.7 percent) targets.

Figure 1-2 displays the 'Ohana CCS' HEDIS MY 2020 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 14 of 20 (70.0 percent) measure rates ranking at or above the 50th percentile. Four of the 14 measure rates (20.0 percent) ranked at or above the 75th percentile but below the 90thpercentile, and four (20.0 percent) met or exceeded the 90th percentile. Conversely, two of 20 (10.0 percent) measure rates fell below the 25th percentile, indicating opportunities for improvement. 'Ohana CCS demonstrated positive performance, meeting nine of the MQD Quality Strategy targets in HEDIS MY 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

In 2021, HSAG validated two PIPs for each of the five QI plans (AlohaCare, HMSA, KFHP, 'Ohana, and UHC CP) and for one CCS plan ('Ohana CCS). The PIP topics for all the QI plans were *Improving Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness (FUH)*. The PIP topics for 'Ohana CCS were *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge*. The PIPs addressed CMS' requirements related to quality outcomes—specifically, access to and timeliness of care and services.

Findings, Conclusions, and Recommendations

In 2021, HSAG validated the Module 4 and Module 5 submissions for two PIPs for each of the QI and CCS health plans, for a total of 12 PIPs. With the submission and validation of Module 4 and Module 5, the projects concluded and HSAG provided a confidence level for each PIP.

Following validation of the health plans' 2021 PIPs, HSAG concluded:

- All five QI health plans received *Low Confidence* in the *Improving Adolescent Well-Care Visits* PIP. The health plans documented coronavirus disease 2019 (COVID-19) pandemic-related provider office closures and member reluctance to go for well visits as factors contributing toward low performance.
- Two QI health plans (AlohaCare and 'Ohana) received *High Confidence* and one health plan (HMSA) received *Confidence* in the *Follow-Up After Hospitalization for Mental Illness (FUH)* PIP. The remaining two QI health plans received *Low Confidence*.
- 'Ohana CCS achieved *High Confidence* for both PIPs.

Table 1-2 summarizes HSAG's key validation findings for the two PIPs conducted by the QI health plans.

Table 1-2—PIP Validation Findings for the QI Health Plans

Health Plan	Improving Adolescent Well-Care Visits		Follow-Up After Hospitalization for Mental Illness (FUH)	
	SMART* Aim Goal Achieved	Confidence Level	SMART Aim Goal Achieved	Confidence Level
AlohaCare QI	*Yes*	*Low Confidence*	*Yes*	*High Confidence*
HMSA QI	*Yes*	*Low Confidence*	*Yes*	*Confidence*
KFHP QI	*No*	*Low Confidence*	*No*	*Low Confidence*
'Ohana QI	*No*	*Low Confidence*	*Yes*	*High Confidence*
UHC CP QI	*No*	*Low Confidence*	*Yes*	*Low Confidence*

**SMART = Specific, Measurable, Achievable, Relevant, and Time-bound*

Table 1-3 summarizes HSAG's key validation findings for the two PIPs conducted by 'Ohana CCS.

Table 1-3—PIP Validation Findings for 'Ohana CCS

	Follow-Up After Hospitalization for Mental Illness		Follow-Up After Emergency Department Visit for Mental Illness	
Health Plan	SMART Aim Goal Achieved	Confidence Level	SMART Aim Goal Achieved	Confidence Level
'Ohana CCS	*Yes*	*High Confidence*	*Yes*	*High Confidence*

Based on the Module 4 and Module 5 validations, HSAG recommends the following:

- When planning an intervention for testing, the health plans should think proactively about the potential barriers to testing the selected interventions. This may help ensure testing of interventions in a timely manner without delays.
- The health plans should ensure that interventions tested for the rapid-cycle PIP reach enough members to impact the SMART Aim, and that data can provide a clear linkage between improvement in the SMART Aim measure results and change(s) tested for the PIP.
- The health plans should ensure complete and accurate documentation of PIP results.
- The health plans should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.
- The health plans should adopt/adapt plan-wide those interventions that were deemed successful.
- The health plans should continue efforts to improve the performance on the PIP topics beyond the SMART Aim end date.

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

The CAHPS health plan surveys are standardized survey instruments which measure parents'/caretakers' experience with their child members' healthcare. For 2021, HSAG administered the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set to child Medicaid members of the QI health plans and a statewide sample of CHIP members who met age and enrollment criteria. All parents/caretakers of sampled child Medicaid and CHIP members completed the surveys from February to May 2021 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.[1-11] Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan and/or state-level CAHPS data.

For each survey, the results of 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

[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 5.1H Child Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required in order to allow parents/caretakers the option to complete the CAHPS survey questionnaire in these alternate languages.

applying this scoring methodology, the proportion (i.e., percentage) of top-box responses was calculated to determine the top-box scores.

Findings, Conclusions, and Recommendations

Table 1-4 presents the 2021 percentage of top-box responses for the QI Program aggregate compared to the 2020 NCQA child Medicaid national averages and the corresponding 2019 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 2020 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-14]

Table 1-4—QI Program Child CAHPS Results

Measure	2019 Scores	2021 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	70.4%	75.1% ▲	★★★
Rating of All Health Care	66.9%	74.9% ▲	★★★
Rating of Personal Doctor	75.6%	81.8% ▲	★★★★
Rating of Specialist Seen Most Often	73.0%	76.4%	★★★★
Composite Measures			
Getting Needed Care	81.2%	83.6%	★
Getting Care Quickly	85.5%	81.9%	★
How Well Doctors Communicate	94.2%	95.4%	★★
Customer Service	85.0%	88.3%	★★
Individual Item Measure			
Coordination of Care	83.8%	88.4%	★★★

Cells highlighted in yellow represent scores that are at or above the 2020 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2020 NCQA child Medicaid national averages.
▲ Indicates the 2021 score is statistically significantly higher than the 2019 score.
▼ Indicates the 2021 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

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 adult population was last surveyed in 2020; therefore, the 2021 child CAHPS scores are compared to the corresponding 2019 scores.
1-14 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020.* Washington, DC: NCQA, September 2020.

Comparison of the 2021 QI Program's scores to the 2020 NCQA child Medicaid national averages revealed the following summary results:

- The QI Program's scores were at or above the national averages 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 averages on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Comparison of the 2021 QI Program's scores to the corresponding 2019 scores revealed the following summary results:

- The 2021 QI Program's score was statistically significantly higher than the 2019 score on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.
- The 2021 QI Program's scores were not statistically significantly lower than the 2019 scores on any measures.

Comparison of the 2021 QI Program's scores to the 2020 NCQA child Medicaid Quality Compass data revealed the following:

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

Table 1-5 presents the 2021 percentage of top-box responses for the Hawaii CHIP population compared to the 2020 NCQA child Medicaid national averages and the corresponding 2020 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 2020 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-15]

Table 1-5—CHIP CAHPS Results

	2020 Scores	2021 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	72.6%	78.2% ▲	★★★★★
Rating of All Health Care	66.6%	74.5% ▲	★★★
Rating of Personal Doctor	76.7%	77.7%	★★
Rating of Specialist Seen Most Often	69.5%+	75.3%+	★★★★

[1-15] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020.* Washington, DC: NCQA, September 2020.

	2020 Scores	2021 Scores	Star Ratings
Composite Measures			
Getting Needed Care	80.4%	87.2% ▲	★★★
Getting Care Quickly	87.8%	82.8%	★
How Well Doctors Communicate	95.9%	97.2%	★★★★
Customer Service	85.1%	82.9%+	★
Individual Item Measure			
Coordination of Care	82.3%	90.4%	★★★★

Cells highlighted in yellow represent scores that are at or above the 2020 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2020 NCQA child Medicaid national averages.
▲ Indicates the 2021 score is statistically significantly higher than the 2020 score.
▼ Indicates the 2021 score is statistically significantly lower than the 2020 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 2021 scores to the 2020 NCQA child Medicaid national averages revealed the following summary results:

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

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

- The CHIP population's 2021 scores were statistically significantly higher than the 2020 scores on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Needed Care.*

Comparison of the CHIP population's scores to the NCQA 2020 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The CHIP population scored at or above the 90th percentile on one measure, *Rating of Health Plan*.
- The CHIP population scored below the 25th percentile on two measures: *Getting Care Quickly* and *Customer Service*.

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

Provider Survey

HSAG conducted a provider survey during 2021 at the request of the MQD. The objective of this activity was to provide meaningful information to the MQD and the QI health plans about providers' perceptions of the QI health plans. The results of the 2021 Hawaii Provider Survey questions were presented by six domains of satisfaction (general positions, providing quality care, non-formulary, service coordinators, specialists, and substance abuse). Response options to each question (i.e., measure) within the six domains were classified into one of three response categories: satisfied, neutral, and dissatisfied; or positive impact, neutral impact, and negative impact. For each measure, the proportion (i.e., percentage) of responses in each response category was calculated. As is standard in most survey implementations, a top-box score is defined by a positive or satisfied response.[1-16]

Findings, Conclusions, and Recommendations

Table 1-6 presents the 2021 percentage of top-box scores for the QI Program aggregate compared to the corresponding 2018 top-box scores, where applicable.[1-17]

Table 1-6—QI Program Provider Survey Results

	2018 Top-Box Score	2021 Top-Box Score	Trend Analysis Significance
General Positions			
Compensation Satisfaction	30.4%	27.6%	—
Timeliness of Claims Payments	45.2%	47.0%	—
Providing Quality Care			
Formulary	21.3%	14.9%	—
Prior Authorization Process	20.1%	17.2%	—
Non-Formulary			
Adequate Access to Non-Formulary Drugs	26.9%	22.2%	—
Service Coordinators			
Helpfulness of Service Coordinators	33.3%	31.8%	—

[1-16] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2021 Hawaii Provider Survey full report located at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/consumer-guides/2021_Hawaii%20Provider%20Survey%20Report_Final.pdf.

[1-17] 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.

	2018 Top-Box Score	2021 Top-Box Score	Trend Analysis Significance
Specialists			
Adequate Network of Specialists	30.5%	24.5%	—
Availability of Mental Health Providers	17.9%	13.6%	—
Substance Abuse			
Access to Substance Abuse Treatment	21.0%	19.2%	—

▲ *Indicates the 2021 top-box score is statistically significantly higher than the 2018 top-box score.*
▼ *Indicates the 2021 top-box score is statistically significantly lower than the 2018 top-box score.*
— *Indicates the 2021 top-box score is not statistically significantly different than the 2018 top-box score.*

Comparison of the 2021 QI Program's top-box scores to the corresponding 2018 top-box scores revealed the following summary results:

- The QI Program scored lower in 2021 than in 2018 on all but one measure (*Timeliness of Claims Payments*), although no measure scores were statistically significantly higher or lower.

The 2021 Provider Survey revealed that dissatisfaction has increased across most survey domains since the 2018 Provider Survey for all QI health plans.

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

- Non-KFHP provider responses indicated consistent dissatisfaction or negative impacts with most key survey domains, while KFHP provider responses indicated satisfied or positive impacts for several survey domains, including formulary, adequate access to non-formulary drugs, helpfulness of service coordinators, adequate network of specialists, and access to substance abuse treatment. HSAG recommends engaging the QI health plans and providers in a time-limited workgroup designed to:
  - Identify and define specific factors influencing providers' level of satisfaction in key survey domains.
  - Identify differences in QI health plan reimbursement strategies and how those strategies impact providers' level of satisfaction with reimbursement.

  It is important to note that the purpose of the workgroup is to better define the issues underlying provider satisfaction levels and to increase engagement with both the provider community and the health plans with which they are contracted.

- Providers contracted with 'Ohana QI and UHC CP QI exhibited substantially higher levels of dissatisfaction compared to the other QI health plans across all survey domains. This finding suggests that healthcare operations surrounding provider reimbursement, service authorizations and coverage, provider networks, and substance abuse treatment for patients may be affecting providers disproportionately for these two health plans. HSAG recommends that the MQD conduct a targeted inquiry of 'Ohana QI and UHC CP QI health plans to identify and evaluate the source and validity of providers' concerns. Based on the results of its review, the MQD can work with 'Ohana QI and UHC CP QI to implement improvement actions, where appropriate, to address provider satisfaction.

  As it relates specifically to the dissatisfaction with 'Ohana QI and UHC CP QI's prior authorization process, HSAG recommends that the MQD, in collaboration with the QI health plans:

  – Conduct a comparative analysis of the prior authorization process implemented by each QI health plan to determine why providers expressed continued dissatisfaction with 'Ohana QI and UHC CP QI.
  – Review each health plan's list of services and procedures requiring prior authorization to determine if 'Ohana QI and UHC CP QI are requiring prior authorization for services that the other health plans do not or should not require prior authorization.

  Based on the results of the above activities, the MQD may recommend or require that 'Ohana QI and UHC CP QI revise their prior authorization processes to reduce the barriers for providers in ordering medically necessary services and procedures.
- In general, a majority of providers surveyed indicated that there is a great lack in availability of mental health providers/specialists for their patients. In reviewing the provider comments, one area of concern was related to no or limited options for therapists between islands. HSAG recommends that the MQD, in collaboration with the QI health plans, implement a time-limited focus group to review concerns related to the lack of availability of mental health providers to determine (1) the degree to which limited to no availability of therapists/specialists impacts patient care across members, and (2) alternative solutions to hiring mental health providers/specialists and coordinating member care.

Encounter Data Validation

The MQD contracted with HSAG to perform an EDV study as part of CMS' *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019.[1-18] The EDV study focused on three activities:

1. Targeted EDV IS assessment
2. Gap analysis and best practice recommendations for data quality assessment
3. Administrative profile

[1-18] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 22, 2021.

The contracted MCOs submit encounter data to the MQD. These encounter data are used for a variety of purposes including capitation rate setting, quality improvement, program evaluation, program monitoring, and submission to CMS as Transformed Medicaid Statistical Information System (T-MSIS) extracts. The MCOs that do not meet certain standards relating to the accuracy, completeness, and timeliness of encounter data may face penalties or CAPs. HSAG examined both encounters that were accepted into the Medicaid Management Information System (MMIS) and suspended ("pended") from the MMIS. The MQD contracts with the Arizona Health Care Cost Containment System (AHCCCS) to process and maintain encounter data in the MMIS.

For the targeted encounter data IS assessment component of the EDV study, representatives from the MQD and the MCOs completed the MQD-approved questionnaires supplied by HSAG. The questionnaire responses were reviewed to assess the MCOs' processes for collecting, adjudicating, managing, and submitting (1) encounter data to the MQD through the AHCCCS MMIS, and (2) the rate files to the State's actuary. This type of evaluation, frequently referred to as an information system assessment in the CMS protocol,[1-19] provides information on the strengths and limitations of the MCOs' information systems in promoting and maintaining quality encounter data.

For the gap analysis and best practice recommendations for data quality assessment, HSAG reviewed practices and/or processes from other state entities to identify best practices for encounter data quality assessments and assessed which of these practices have been operationalized into the MQD EDV and reporting protocols.

Findings, Conclusions, and Recommendations

Targeted Encounter Data Information Systems Assessment

Based on the questionnaire responses, the MCOs provided information demonstrating their capacity to collect, process, and transmit to the MQD claims and encounter data meeting established quality specifications. Although each MCO employs different strategies to facilitate accurate and timely encounter data submissions, each MCO described the centrality of its encounter data systems and data warehouse and its ability to develop adaptable data review processes that can adequately respond to quality issues identified by the MQD. All MCOs described the role of internal personnel and departments; software systems and external vendors employed for activities such as claims adjudication, provider, and member information verification; management of third-party liability (TPL) information; and processing the encounter data reconciliation and rate files. When necessary, the MCOs described the vendor oversight and data remediation activities that they have in place to ensure the completeness and accuracy of data submitted to them or processed on their behalf.

While the MQD offers the MCOs substantial autonomy regarding the development and management of their encounter data systems, it does require the MCOs to submit complete and accurate encounter data in a timely manner. Based on reviews of the MCOs' questionnaire responses, while the MCOs provided descriptions on how they monitor accuracy, completeness, and timeliness of encounter data submitted

[1-19] Ibid.

by their vendor(s) and/or providers, the MCOs' monitoring efforts vary, where not all MCOs have a robust data monitoring process.

Reviews of the MCOs' questionnaire responses found that, while the average rejection rate for encounters rejected by the MQD's electronic data interchange (EDI) translator was low, the average rejection rate for encounters that were rejected by the MQD's MMIS was high, with a rejection rate of more than 15 percent. The MCOs noted that most rejected (pended) encounters are due to provider-related issues (e.g., provider enrollment/activation, provider category of service). At the time of the response submission, the MQD acknowledged that it is in the process of transitioning provider data flows from the previous process, which created a large volume of backlog, to a new provider system, Hawaii's Online Kahu Utility (HOKU), to alleviate the provider-related issues encountered during data processing.

All MCOs have processes in place when extracting, preparing, and submitting the rate files to the MQD's actuary, Milliman, and the encounter data reconciliation files (i.e., the triangle report) to the MQD. The MCOs noted differences in data sources, and inclusions/exclusions criteria of costs/data used in preparation of these files. While the MCOs did not experience any challenges in extracting, preparing, and submitting the encounter data reconciliation files, the MCOs cited a few challenges with the rate file processing. Some of the challenges cited included having to use multiple systems which hold data that were needed to report; meeting a specified deadline wherein certain claims may not be available until after the specified deadline; the short time span to complete the data request; and gaps or discrepancies that exist between the MQD-provided specifications and internal conventions, causing the MCO to make assumptions regarding how best to map data.

Gap Analysis and Best Practice Recommendations for Data Quality Assessment

HSAG conducted an environmental scan to evaluate how Florida, Hawaii, Iowa, New Hampshire, Ohio, and Virginia ensure that the encounter data from the MCOs are complete, accurate, and submitted in a timely manner. Since this activity was conducted to solely assist the MQD in identifying best practices for encounter data quality assessments, there were no MCO-specific findings to report.

Administrative Profile

Overall, the MCOs' encounter data submitted to the MQD's data warehouse should support future analyses such as HEDIS performance measure calculation. Data were largely complete, valid, and reliable. While some data issues were identified during completion the Administrative Profile activity, it should not preclude the State from conducting further analysis. Notable gaps included:

- Missing pharmacy encounters from KFHP QI in August 2019.
  - Impact: If not addressed, this could adversely impact performance measure rates that use pharmacy data. Rates may still be calculated with appropriate caution of incomplete data.
- Inconsistent payment for KFHP QI professional and pharmacy encounters.
  - Impact: The MQD and its vendors may need to allow sufficient run-out prior to conducting analysis to ensure data are complete for KFHP QI.

- Longer than usual lag in payment among professional, inpatient, and outpatient encounters for some MCOs.
  - Fewer than 90 percent of AlohaCare QI and 'Ohana QI encounters for professional, inpatient, and hospital outpatient were paid within 180 days.
  - Fewer than 90 percent of UHC CP QI encounters for professional and inpatient were paid within 180 days.
  - Fewer than 90 percent of KFHP QI encounters for professional and pharmacy were paid within 180 days.
  - Impact: The MQD and its vendors may need to allow additional run-out time between the date of service and encounter payment to ensure a sufficient percentage of encounters are included for analyses. Otherwise, data may be incomplete and/or comparisons across MCOs may be biased due to the differential in lag among MCOs.
- Large volume of suspended long-term care (LTC) encounters for UHC CP QI throughout 2019.
  - Impact: To the extent encounters are suspended and not accepted into the MMIS, analyses related to LTC may show lower costs and/or utilization for UHC CP QI.
- Nearly half of the rendering/servicing provider National Provider Identifiers (NPIs) in encounters across all MCOs were not found in the provider reference file. However, these providers only accounted for approximately 5 percent of all encounters.
  - Impact: Additional investigation showed rendering Medicaid IDs were sufficiently found in the provider reference file. Using Medicaid provider IDs for analysis should yield valid results.

Recommendations

- Targeted IS assessment:
  - Based on the IS assessments, the average rejection (pended) rates for encounters that were rejected by the MQD's MMIS were high among all the MCOs. The MCOs cited and identified that a high percentage of pends were provider related. At the time of the questionnaire response submission, the MQD acknowledged that it is in the process of transitioning provider data flows from the previous process to a new provider system, HOKU. As such, the MCOs are recommended to work with the MQD to ensure requirements and/or any changes are implemented accordingly during this transition period.
  - Additionally, during the MQD's provider system transition period, to ensure submission of accurate provider information, the MCOs are recommended to continue their oversight activities in this area. This will allow the MCOs to identify any potential issues related to provider data when claims/encounters are received in their systems. This approach would minimize any provider data anomalies noted at the very end of the MCOs' encounter submission process and allow the MCOs to work with their contracted providers to ensure information is provided accurately when the claims are first submitted to the MCOs.
  - A lack of standardized monitoring by the MCOs to ensure accuracy and completeness of encounter data was identified. As such, the MCOs should consider the following recommendations:

    - Adding standardized metrics to actively monitor encounter data completeness and accuracy. Some examples include reviewing encounter volume by month, reviewing high-dollar claims, and establishing trends.
    - Conducting validation of encounter data annually using a sample of medical record reviews.
    - Submitting their monitoring results to the MQD for use in ongoing data monitoring.
  - The reviews also revealed that not all MCOs have a robust process for monitoring the timeliness of claims and encounter data submitted by vendors and/or providers. As such, the MCOs should consider implementing additional metrics to actively monitor whether encounter data were submitted in a timely manner. Additionally, MCOs should consider producing standardized monitoring reports that can be submitted to the MQD for use in its ongoing data monitoring.
- Administrative profile review recommendations:
  - AlohaCare QI, ‘Ohana QI, and UHC CP QI should ensure professional and inpatient encounters are paid and submitted to the MMIS in a timely manner.
  - AlohaCare QI and ‘Ohana QI should ensure hospital outpatient encounters are paid and submitted in a timely manner.
  - KFHP QI should ensure professional and pharmacy encounters are submitted to the MMIS in a timely manner.
  - Short term: MCOs should report both Medicaid provider IDs and NPIs consistently on encounters.
  - Short term: UHC CP QI should collaborate with the MQD to review pended encounter reports from MMIS to determine the root cause for suspension of encounters, particularly among LTC encounters.

2. Introduction

Purpose of the Report

As required by 42 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/Rules and Regulations. 42 CFR Parts 431, 433 and 438 with revisions released (or as amended) November 13, 2020, Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Dec 10, 2021.

strategy for assessing and improving the quality of healthcare and services furnished by the MCO, PIHP, PAHP, or PCCM entity.

Compliance Reviews

In accordance with 42 CFR §438.358, the state or its designee must conduct a review within the previous three-year period to determine the MCO's, PIHP's, PAHP's, or PCCM entity's compliance with federal standards and associated state-specific requirements, when applicable. 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 PMV 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 both clinical and nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing interventions to achieve improvement in the access to and quality of care
- 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 and Provider Surveys

Administration of consumer or provider 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 to assist them in conducting activities related to the mandatory and optional activities described in this section that provide information for the EQR and the resulting EQR technical report.

Summary of Report Content

Encompassing a review period from January 1, 2021, through December 31, 2021, 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, three 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
    - Administration of provider survey
    - 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 440,000[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 adopted its core values through *Hi'iola*, meaning "to embrace wellness":

Healthy Outcomes—We develop strategies and improvements necessary to promote overall wellbeing.

Integrity—We are accountable to the work we do, the resources we manage and the people we serve.

'Ohana Nui—We focus on the whole family's needs, with priority on children ages 0–5 years old.

Innovation—We cultivate an atmosphere of continuous learning and improvement.

Optimism—We each make a difference for the people of Hawai'i.

Leadership—We are all leaders in the work we do.

Aloha—We extend warmth and caring to all.

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 (LTSS) 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

[2-2] All Medicaid enrollment statistics cited in this section are as of September 2021, as cited in *Hawaii Medicaid Enrollment (2021)*. Available at: https://medquest.hawaii.gov/en/resources/reports.html. Accessed on: Dec 10, 2021.

[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: Dec 10, 2021.

services to Hawaii's Medicaid/CHIP population. Each of the QI health plans administer all benefits to enrolled members, including primary, preventive, acute, and LTSS. 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 more than 80,000 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 200,000 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 48,000 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 41,000 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 62,000 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 Hawaii Quality Strategy was filed with and approved by CMS in 2020. 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. In 2017, the MQD launched the Hawaii 'Ohana Nui Project Expansion (HOPE) program to develop and implement a roadmap to achieve a vision of healthy families and healthy communities. The goal of HOPE is to achieve the Triple Aim of better health, better care, and sustainable costs for the community. The HOPE initiative guides the Medicaid Quality Strategy.

While the MQD Quality Strategy Leadership Team (QSLT) is responsible for initiating the development of, and updates to the quality strategy, the Quality Assurance team and the Quality Improvement team are tasked with conducting the quality oversight activities. The quality teams use monthly, quarterly, and annual reporting from their EQRO and MCOs to monitor success in meeting the key goals/measures of the Quality Strategy.

Each quarter, the Quality Assurance team reviews reports submitted by the MCOs and analyzes the data for trending, timeliness, completeness, accuracy, and conformance with contract requirements. Findings from the report analysis are then communicated back to the MCOs. The Quality Improvement team

[2-4] Hawai'i Quality Strategy 2020. State of Hawaii, Department of Human Services, Med-QUEST Division. Available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/MQD_Quality_Strategy_Master_FINAL.pdf Accessed on: Dec 10, 2021.

manages seven quality program committees that meet quarterly; review quality reports submitted by the MCOs; and actively assess delivery system and health plan affiliated actions, trends, and outcomes. The Quality Improvement team is also responsible for oversight of the Quality Payment Program (QPP). The QPP allows the MCOs to be eligible for financial performance incentives or pay for performance (P4P) as long as the MCO is fully compliant with all terms of the contract, particularly those overseen by the quality assurance team.

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 quality strategy goals 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, PMV and HEDIS audits, validation of performance improvement projects, child and CHIP population CAHPS survey, provider survey, encounter data validation, 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 adults, women and children, healthcare for individuals who have chronic conditions, the provision of LTSS and behavioral health 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 has also defined additional measures that address access to, and provision of HCBS. A subset of measures is incorporated into the MQD's Pay-for-Performance (P4P) incentive program.
- The MQD and HSAG continued to work with the health plans in implementing a rapid-cycle PIP framework to test and refine interventions through a series of PDSA cycles designed to facilitate more efficient and long-term sustained improvement.

The MQD continues to focus on initiatives to improve the quality and timeliness of, and access to care based on the strategic goals and associated objectives. Based on EQR findings for 2021, HSAG recommends the following to target and improve statewide performance and achieve selected goals and objectives.

Goals, Objectives, and Statewide Recommendations

Goal 1: Advance primary care, prevention, and health promotion

Objectives

- Enhance timely and comprehensive pediatric care.
- Reduce unintended pregnancies and improve pregnancy-related care.
- Increase utilization of adult preventive screenings in the primary care setting.
- Expand adult primary care preventive services.

Recommendations

- Conduct a program-wide focus group of women on Medicaid who have recently given birth or are pregnant to determine potential barriers to timely access to prenatal care.
- Encourage health plans to evaluate the accuracy, completeness, readability level, content, and frequency of member communications, such as member newsletters, to improve member understanding and engagement in preventive healthcare.

Goal 2: Integrate behavioral health with physical health across the continuum of care

Objectives

- Promote behavioral health integration and build behavioral health capacity.
- Support specialized behavioral health services for serious intellectual/developmental disorders, mental illness, and substance use disorders (SUD).

Recommendations

- Continue to encourage information sharing, collaboration, and care coordination among health plans and State agencies that provide services to Medicaid members.
- Continue to promote and increase the use of telemedicine.
- Consider implementing incentive programs to encourage advanced practice registered nurses and PCPs to obtain mental health training.

Goal 3: Improve outcomes for high-need, high-cost individuals

Objectives

- Provide appropriate care coordination for populations with special healthcare needs.
- Provide team-based care for beneficiaries with high-need, high-cost conditions.
- Advance care at the end of life.
- Provide supportive housing to homeless beneficiaries with complex health needs.

Recommendations

- Reward creative care coordination programs or initiatives that strive to ensure members receive timely assessments and healthcare services that prevent and treat identified conditions and assess and refer members to appropriate community partners to address social determinants of health (SDoH).
- Encourage communication and collaboration among health plans, providers, and State agencies in coordinating care among beneficiaries with high-need, high-cost conditions.
- Continue to facilitate and enhance relationships with housing agencies.

Goal 4: Support community initiatives to improve population health

Objectives

- Assess and address SDoH needs.

Recommendations

- Continue to strengthen community partnerships and encourage health plans to continue to invest in the communities they serve.
- Encourage collaboration among the health plans and the State on program-wide solutions that address SDoH.

Goal 5: Enhance care in LTSS settings

Objectives

- Enhance community integration/reintegration of LTSS beneficiaries.
- Enhance nursing facility and HCBS; prevent or delay progression to nursing facility level of care.

Recommendations

- Consider adding LTSS measures to the list of audited measures to be validated during the PMV activity. Results will help the MQD determine areas to focus on and validated measures/rates may be used in conjunction with the State's incentive programs (P4P, auto-assignment) to drive quality outcomes.
- Provide enhanced payment to Community Care Foster Family Homes (CCFFH) that accept LTSS members deemed "difficult to place" due to a combination of challenging physical and behavioral health needs.

Goal 6: Maintain access to appropriate care

Objectives

- Maintain or enhance access to care.
- Increase coordination of care and decrease inappropriate care.

Recommendations

- Consider adding validation of network adequacy activities as part of EQR to ensure access standards are being met.
- Select a third PIP topic that focuses on improving members' access to care.

Goal 7: Align payment structures to improve health outcomes

Objectives

- Align payment structures to support work on SDoH.
- Align payment structures to enhance quality and value of care.

Recommendations

- Continue and enhance P4P to the health plans through enhanced payment for meeting key performance indicator goals.
- Continue and enhance the quality-based auto-assignment program to incentivize health plans for meeting specified quality measures.
- Consider developing a quality-based incentive program targeting the implementation of health plan interventions and initiatives that address SDoH.
- Implement strategies to critically evaluate the accuracy of the health plans' encounter data and encourage the health plans to conduct ongoing quality monitoring beyond any EDV activities conducted during EQR.

3. Assessment of Health Plan Performance

Introduction

This section of the report describes the results of HSAG's 2021 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 QI members. Additionally, recommendations are offered to each health plan to facilitate continued quality improvement in the Medicaid program.

Methodology

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

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

  Quality, as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity increases the likelihood of desired outcomes of its enrollees through:
  - Its structural and operational characteristics.
  - The provision of services that are consistent with current professional, evidence-based knowledge.
  - Interventions for performance improvement.[3-1]
- **Access**—CMS defines "access" in the final rule at 42 CFR §438.320 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 a situation."[3-3] NCQA further discusses the intent of this standard as being to minimize any

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction,* October 2019.
[3-2] Ibid.
[3-3] National Committee for Quality Assurance. 2020 Standards and Guidelines for Accreditation of Health Plans.

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]

HSAG analyzes the quantitative results obtained from each EQR activity for each health plan to identify strengths and weaknesses in each domain—quality, timeliness, and access—related to the care and services furnished by the health plan for the EQR activity. Second, from the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about the overall quality of care, timeliness of care, and access to care and services furnished by the health plan. Lastly, HSAG identifies any patterns and commonalities that exist across the program to draw aggregated conclusions about the quality of care, timeliness of care, and access to care for the program.

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 2021 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 2021 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2020 review.

Findings

Table 3-1 presents the scores from HSAG's 2020 compliance review, the number of CAPs required, and the results of the 2021 follow-up reviews of AlohaCare QI.

[3-4] Agency for Healthcare Research and Quality. *National Healthcare Quality and Disparities Report.* AHRQ Publication No. 16-0015-5-EF. May 2016.
[3-5] Ibid.

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

Standard #	Standard Name	2020 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2021 Final Follow-Up Review Score
I	Provider Selection	90%	1	1	**100%**
II	Subcontracts and Delegation	95%	1	1	**100%**
III	Credentialing	100%	0	NA	**100%**
IV	Quality Assessment and Performance Improvement	100%	0	NA	**100%**
V	Health Information Systems	100%	0	NA	**100%**
VI	Practice Guidelines	100%	0	NA	**100%**
VII	Program Integrity	100%	0	NA	**100%**
VIII	Enrollment and Disenrollment	100%	0	NA	**100%**
	Totals	**99%**	**2**	**2**	**100%**

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

Strengths

Since AlohaCare QI performed well during the 2020 compliance review, only two corrective action items needed to be completed in 2021. To address the *Provider Selection* standard deficiency, AlohaCare QI updated its *Provider Contract Termination* and *Practitioner, Corrective Action, Suspension and Termination* policies and procedures to ensure written notification is sent to providers if AlohaCare QI declines to include an individual provider or provider group in its network. In addition, AlohaCare QI conducted a training with staff members on the policy requirements and workflow processes. To address the *Subcontracts and Delegation* standard deficiency, AlohaCare QI executed contract amendments with two of its subcontractors (AllMed Health Care Management and Carenet Health) that included the correct timelines for medical record retention (10 years) in compliance with the State's health plan contract.

Areas for Improvement

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

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated AlohaCare QI's IS capabilities for accurate HEDIS reporting. AlohaCare QI was found to be *Fully Compliant* with all HEDIS IS assessment standards. This demonstrated that AlohaCare QI generally had the necessary systems, information management practices, processing environment, and control procedures in place to access, capture, translate, analyze,

and report the selected measures. AlohaCare QI presented five standard supplemental data sources and one nonstandard data source to review for MY 2020 reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2020 performance measure reporting.

AlohaCare QI passed medical record review validation (MRRV) in the prior year, and its medical record review (MRR) processes did not significantly change; therefore, AlohaCare QI was not required to submit a convenience sample. MRRV was conducted for the following measures and corresponding measure groups as well as all medical record exclusions, and all records passed the validation without any critical issues:

- Group A: Biometrics (Body Mass Index [BMI], Blood Pressure [BP]) & Maternity—*Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
- Group C: Laboratory—*Cervical Cancer Screening*
- Group D: Immunization & Other Screenings—*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- Group F: Exclusions—All Medical Record Exclusions

Excluding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 6–17 years and 65 years and older stratifications, all QI measures that AlohaCare QI was required to report were determined to be *Reportable*. A status of *NA* (i.e., *Small Denominator*) was assigned for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 6 to 17 years and 65 years and older stratifications. AlohaCare QI followed the required specifications, but the denominator was too small to report a valid rate.

Because AlohaCare QI was found to be fully compliant during the NCQA HEDIS Compliance Audit, the auditors did not have any recommendations for AlohaCare QI.

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. The *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* met or exceeded the 75th percentile. The *Heart Failure Admission Rate* measure did not have an applicable benchmark; therefore, no comparison to national benchmarks is presented. One measure in this domain had an MQD Quality Strategy target (i.e., *Heart Failure Admission Rate—Total*), and AlohaCare QI met the target for HEDIS MY 2020.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Heart Failure Admission Rate*				
18–64 Years	60.08	42.95	-28.51%	NC

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
65 Years and Older	182.65	147.04	-19.50%	NC
Total	71.71	53.26	-25.73%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	8.37%	8.46%	1.08%	★★★★
Expected Readmissions—Total	—	10.14%	—	NC
*Index Total Stays—O/E Ratio—Total**	0.86	0.83	-2.92%	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Children's Preventive Health Performance Measure Results

AlohaCare QI's Children's Preventive Health performance measure results are shown in Table 3-3. The *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures were new HEDIS measures; therefore, there were no prior year rates to compare to and no available benchmarks. The *Childhood Immunization Status—Combination 3* rate demonstrated a decline of more than 15 percent for MY 2020 and the applicable vaccination rates demonstrated a decline of more than 5 percent, except for *VZV*, which demonstrated a decline of less than 5 percent. Additionally, 18 measure rates fell below the 50th percentile, with 14 of these measure rates falling below the 25th percentile. One measure in this domain had an MQD Quality Strategy target for HEDIS MY 2020 (i.e., *Childhood Immunization Status—Combination 3*), and AlohaCare QI did not reach the established target.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Child and Adolescent Well-Care Visits[1]				
3–11 Years	—	45.75%	—	NC
12–17 Years	—	41.53%	—	NC
18–21 Years	—	16.67%	—	NC
Total	—	39.80%	—	NC
Childhood Immunization Status				
Combination 2	—	56.69%	—	★

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Combination 3	64.48%	53.53%	-16.98%	★
Combination 4	—	51.82%	—	★
Combination 5	—	45.99%	—	★
Combination 6	—	40.15%	—	★★
Combination 7	—	44.53%	—	★
Combination 8	—	39.17%	—	★★
Combination 9	—	34.06%	—	★★
Combination 10	—	33.33%	—	★★
DTaP	69.83%	62.53%	-10.45%	★
Hepatitis A	—	74.45%	—	★
Hepatitis B	82.00%	74.21%	-9.50%	★
HiB	81.27%	76.16%	-6.29%	★
Influenza	—	52.31%	—	★★★
IPV	81.51%	76.89%	-5.67%	★
MMR	82.48%	78.10%	-5.31%	★
Pneumococcal Conjugate	69.10%	59.85%	-13.39%	★
Rotavirus	—	58.64%	—	★
VZV	81.51%	78.10%	-4.18%	★
Well-Child Visits in the First 30 Months of Life[1]				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	—	60.38%	—	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	68.26%	—	NC

[1] *Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

Women's Health Performance Measure Results

AlohaCare QI's Women's Health performance measure results are shown in Table 3-4. Two rates in this domain demonstrated a relative decrease of more than 7 percent for HEDIS MY 2020. Two measure rates that could be compared to national benchmarks fell below the 25th percentile, and one measure

rate met or exceeded the 50th percentile. Three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2020. AlohaCare QI met the quality target for one of these measure rates (i.e., *Prenatal and Postpartum Care—Postpartum Care*).

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Cervical Cancer Screening[1]				
Cervical Cancer Screening	54.50%	50.61%	-7.14%	★
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	88.08%	81.27%	-7.73%	★
Postpartum Care	79.81%	76.64%	-3.97%	★★★

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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*

MY 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. Two rates in this domain reported a relative decrease of more than 6 percent. Four measure rates that could be compared to national benchmarks ranked below the 50th percentile, and one of these measure rates fell below the 25th percentile. MY 2020 represented the first year for reporting the non-HEDIS measure *Concurrent Use of Opioids and Benzodiazepines*; therefore, no prior year's rate is presented. Five measure rates[3-6] within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2020, and AlohaCare QI did not reach the established targets.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing[2]	88.08%	82.73%	-6.07%	★
*HbA1c Poor Control (>9.0%)**[2]	35.28%	39.66%	12.41%	★★

[3-6] 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 MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
HbA1c Control (<8.0%)[2]	53.53%	49.64%	-7.27%	★★
Eye Exam (Retinal) Performed[2]	58.64%	58.15%	-0.84%	★★
Blood Pressure Control (<140/90 mm Hg)[1]	—	54.74%	—	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	—	9.77%	—	NC
65 Years and Older	—	12.20%	—	NC
Total	—	10.00%	—	NC

[1] *Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.*

[2] *Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*

** A lower rate indicates better performance.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

Behavioral Health Performance Measure Results

AlohaCare QI's Behavioral Health performance measure results are shown in Table 3-6. The *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up—Total* and *30 Day Follow-Up—Total* indicators demonstrated a relative increase; however, four measure rates that could be compared to national benchmarks ranked below the 50th percentile, and one of these measure rates fell below the 25th percentile. MY 2020 represented the first year for reporting the non-HEDIS measures *Screening for Depression and Follow-Up Plan* and *Use of Pharmacotherapy for Opioid Use Disorder*; therefore, no prior years' rates are presented. Two measure rates[3-7] within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2020, and AlohaCare QI did not reach the established targets.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Follow-Up After Hospitalization for Mental Illness[1]				

[3-7] 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 MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
7-Day Follow-Up—6–17 Years	—	NA	—	NC
7-Day Follow-Up—18–64 Years	—	30.57%	—	★★
7-Day Follow-Up—65+ Years	—	NA	—	NC
7-Day Follow-Up—Total	19.09%	30.65%	60.56%	★★
30-Day Follow-Up—6–17 Years	—	NA	—	NC
30-Day Follow-Up—18–64 Years	—	44.54%	—	★★
30-Day Follow-Up—65+ Years	—	NA	—	NC
30-Day Follow-Up—Total	38.79%	44.44%	14.57%	★
Screening for Depression and Follow-Up Plan				
12–17 Years	—	20.27%	—	NC
18–64 Years	—	6.65%	—	NC
65 Years and Older	—	12.34%	—	NC
18 Years and Older	—	7.27%	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	—	48.09%	—	NC
Buprenorphine	—	28.95%	—	NC
Oral Naltrexone	—	1.20%	—	NC
Long-Acting, Injectable Naltrexone	—	0.00%	—	NC
Methadone	—	20.33%	—	NC

[1] *Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Conclusions and Recommendations

Based on HSAG's analyses of AlohaCare QI's 31 measure rates comparable to benchmarks, three measure rates (9.7 percent) ranked at or above the 50th percentile, with one of these rates (3.2 percent) ranking at or above the 75th percentile. The *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* measure rate that ranked at or above the 75th percentile demonstrates that AlohaCare QI had a lower rate of patient hospital readmissions than expected, which indicates positive quality of care performance in the hospital, such as appropriate post-discharge planning and care coordination, resulting in a lower amount of unplanned hospital readmissions within 30 days of

being discharged. A lower number of readmissions within 30 days is important because unplanned readmissions are associated with increased mortality and higher health costs. The *Prenatal and Postpartum Care—Postpartum Care* measure rate ranked at or above the 50th percentile, which indicates members are receiving timely postpartum care, which is beneficial in establishing the long-term health and well-being of new mothers and their infants. Additionally, the *Influenza* vaccination rate for the *Childhood Immunization Status* measure ranked at or above the 50th percentile, indicating positive performance for this particular vaccine.

Conversely, 28 of AlohaCare QI's measure rates comparable to benchmarks (90.3 percent) fell below the 50th percentile, with 18 rates (58.1 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 MY 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:

- Children's Preventive Health
  - *Childhood Immunization Status—Combinations 2, Combination 3, Combination 4, Combination 5, Combination 7, DTaP*, *Hepatitis A, Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate*, *Rotavirus,* and *VZV*
- Women's Health
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care—HbA1c Testing*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

Validation of Performance Improvement Projects

For validation year 2021, AlohaCare QI completed and submitted Module 4 and Module 5 for the *Improving Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness (FUH)* PIPs. These PIPs were initiated in CY 2019, and this was the final validation.

Findings

Module 4: Plan-Do-Study-Act

Module 4 is the intervention testing phase of the rapid-cycle PIP. In this module, the health plan conducts small tests of change using Plan-Do-Study-Act (PDSA) cycles. HSAG conducted two periodic

check-ins during the intervention testing phase to review the health plan's progress into the intervention testing and provide feedback.

Improving Adolescent Well-Care Visits

The health plan tested two interventions during this PIP:

1. Member Outreach via Nanosite: This intervention was tested from July 2020 through September 2020. During the check-ins, HSAG noted an opportunity for the health plan to improve data collection for the intervention effectiveness measure. The health plan addressed HSAG's feedback in the final Module 4 submission. During the intervention testing period, out of a total of 58 members who were engaged via the nanosite, seven members had a compliant adolescent well-care visit. The intervention was deemed ineffective, and the health plan decided to abandon the intervention.
2. Member Incentive: This intervention was tested from October 2020 through January 2021. Icario, formerly known as NovuHealth, provided outreach to educate on the importance of well-care visits while providing an incentive to those members who completed visits. Icario used an Omni-channel communication-integrated system, through which Icario interacted with members through several modes of communication (call center, mail stream channel-inbound and outbound, interactive voice response system, digital platform, email, text, and Web portal). In the intervention plan, HSAG noted an opportunity for the health plan to improve the representation of data. The health plan addressed HSAG's feedback in the final Module 4 submission. According to the health plan, the outcome of this intervention was successful, having an overall compliancy of 66.4 percent (87/131) for members engaged. The health plan decided to adopt this intervention.

Follow-Up After Hospitalization for Mental Illness

The health plan tested the following intervention during this PIP: Contracting with a behavioral health provider (Care Hawaii) to provide 7-day follow-up visits. During the check-ins, HSAG noted possible errors in the reported SMART Aim and intervention effectiveness measure data. The health plan addressed HSAG's feedback in the final Module 4 submission. The intervention was initially tested for three months beginning April 2020 on members discharged from Castle Medical Center; however, beginning July 13, 2020, the intervention was also expanded to Queens Medical Center. The health plan reported success with the intervention, with 37 of the 159 members who received the intervention having a compliant *FUH* visit at the contracted behavioral health provider. The health plan indicated that when the contracted behavioral health provider was on vacation, it affected the compliancy rates, therefore indicating a clear linkage of the intervention to improvement. The health plan decided to adopt this intervention.

Module 5: PIP Conclusions

HSAG organized and analyzed AlohaCare QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. The validation findings for AlohaCare QI's PIPs are presented in Table 3-7 and Table 3-8.

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Improving Adolescent Well-Care Visits

Table 3-7—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Increase the percentage of adolescent well-care visits among 18–20-year-olds located in Waianae and Waipahu from 14.92% to 17.71% by 1/31/2021.	14.92%	17.71%	20.0%	*Low Confidence*

Based on the intervention evaluation results and the SMART Aim run chart, the health plan met the SMART Aim goal before the intervention testing began. Even though it appears that one of the interventions has the potential to result in improvement, it could not be directly linked to improvement in the SMART Aim measure rate. Therefore, HSAG assigned the PIP a score of *Low Confidence*.

AlohaCare QI documented the following lessons learned for the *Improving Adolescent Well-Care Visits* PIP:

- An outreach intervention should not rely solely on text messages because a good portion of the phone numbers were inaccurate for the target population.
- The second intervention took an Omni-channel communication-integrated system approach for conducting outreach, and the result proved to be more successful. The Icario log-in website also allows members to update their best contact information, which they are more likely to provide when enrolled in an incentive program.
- Continuously improving the accuracy of member contact information is vital for any intervention directed at member engagement, regardless of how well the message is tailored to the target audience.

Follow-Up After Hospitalization for Mental Illness (FUH)

Table 3-8—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By January 31, 2021, increase the percentage of compliance for 7-day follow-up after hospitalization for mental illness or intentional self-harm (FUH) for members 18–64 years of age from 15.5% to 21.4%.	15.5%	21.4%	30.0%	*High Confidence*

Based on the intervention evaluation results and the SMART Aim run chart, the health plan met the SMART Aim goal, and it appears the tested intervention could be reasonably linked to the improvement achieved. Therefore, HSAG assigned the PIP a score of *High Confidence*.

AlohaCare QI documented the following lessons learned for the *Follow-Up After Hospitalization for Mental Illness (FUH)* PIP:

- Preventable challenges met should be added to the "to do" list during the planning stage, such as checking billing timeliness early in the intervention process.
- The face-to-face meetings with the member during the inpatient stay are crucial to adequate member engagement.

Strengths

- AlohaCare QI was successful in achieving desired outcomes for the *Follow-Up After Hospitalization for Mental Illness (FUH)* PIP.
- The health plan addressed HSAG's feedback during the PIP check-ins.

Areas for Improvement

- For the *Improving Adolescent Well-Care Visits* PIP, even though it appears that one of the tested interventions has the potential to result in improvement, it could not be clearly linked to improvement in the SMART Aim measure rate. The health plan should ensure it is reaching an adequate number of members with an intervention to be able to reach the SMART Aim goal.
- The health plan should aim toward continuously improving the accuracy of member contact information. This is vital for any intervention directed at member engagement, regardless of how well the message is tailored to the target population.

Recommendations

- When planning an intervention for testing, AlohaCare QI should think proactively about the potential barriers to testing the selected interventions. This may help ensure testing of interventions in a timely manner without delays.
- AlohaCare QI should ensure complete and accurate documentation of PIP results, including the monthly numerators and denominators for the SMART Aim measures, and numerator and denominator data for the intervention effectiveness measures.
- AlohaCare QI should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.
- AlohaCare QI should adopt/adapt plan-wide the interventions that were deemed successful.
- AlohaCare QI should continue its efforts to improve the performance on the PIP topics beyond the SMART Aim end date.

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

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

Findings

Table 3-9 presents the 2021 percentage of top-box responses for AlohaCare QI compared to the 2020 NCQA child Medicaid national averages and the corresponding 2019 scores.[3-8,3-9] Additionally, the overall member experience ratings (i.e., star ratings) resulting from AlohaCare QI's top-box scores compared to NCQA's 2020 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-10]

Table 3-9—Child Medicaid CAHPS Results for AlohaCare QI

Measure	2019 Scores	2021 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	72.5%	75.3%	★★★
Rating of All Health Care	68.4%	73.9%	★★★
Rating of Personal Doctor	76.5%	82.2%	★★★★
Rating of Specialist Seen Most Often	71.7%+	78.6%+	★★★★★
Composite Measures			
Getting Needed Care	82.2%	80.1%+	★
Getting Care Quickly	85.5%	79.2%+	★
How Well Doctors Communicate	91.9%	94.1%	★
Customer Service	87.1%+	83.9%+	★
Individual Item Measure			
Coordination of Care	81.3%+	87.2%+	★★★

Cells highlighted in yellow represent scores that are at or above the 2020 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2020 NCQA child Medicaid national averages.
▲ Indicates the 2021 score is statistically significantly higher than the 2019 score.
▼ Indicates the 2021 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

3-8 The adult population was last surveyed in 2020; therefore, the 2021 child CAHPS scores are compared to the corresponding 2019 scores.

3-9 National Committee for Quality Assurance. *HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2020.

3-10 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020*. Washington, DC: NCQA, September 2020.

Strengths

For AlohaCare QI's child Medicaid population, the following five measures met or exceeded the 2020 NCQA child Medicaid national averages:

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

In addition, the following measure met or exceeded the 90th percentile:

- *Rating of Specialist Seen Most Often*

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 AlohaCare QI.

Areas for Improvement

HSAG performed an analysis of the 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 3-10 provides a summary of the key drivers identified for AlohaCare QI.

Table 3-10—AlohaCare QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Ease of getting the care, tests, or treatment the child needed		✓	
Child's personal doctor seemed informed and up to date about care the child received from other doctors or health providers	✓	✓	✓
The customer service area for the child's health plan gave the parent/caretaker the information or help needed	✓		**N/A**
Ease of filling out forms from the child's health plan		✓	**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 to and timeliness of care for AlohaCare QI:

- 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 an area for improvement in quality of care for AlohaCare QI:

- 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 the customer service area of their child's health plan did not always give them the information or help they needed.
- Respondents reported that forms from their child's health plan were often not easy to fill out.

Provider Survey

The following is a summary of the Provider Survey performance highlights for AlohaCare QI.

Findings

Table 3-11 presents the 2021 top-box scores compared to the QI Program aggregate and the corresponding 2018 top-box scores, where applicable, on the six domains of satisfaction for AlohaCare QI.[3-11]

Table 3-11—Provider Survey Results for AlohaCare QI

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	36.9%	34.4%	27.6%	↑	—
Timeliness of Claims Payments	56.4%	52.8%	47.0%	↑	—
Providing Quality Care					
Formulary	19.3%	17.9%	14.9%	—	—

[3-11] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2021 Hawaii Provider Survey full report.

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
Prior Authorization Process	19.6%	21.7%	17.2%	↑	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	22.6%	28.1%	22.2%	↑	▲
Service Coordinators					
Helpfulness of Service Coordinators	37.3%	35.4%	31.8%	—	—
Specialists					
Adequate Network of Specialists	23.7%	20.6%	24.5%	—	—
Availability of Mental Health Providers	16.2%	15.5%	13.6%	—	—
Substance Abuse					
Access to Substance Abuse Treatment	19.6%	23.0%	19.2%	↑	—

↑ *Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2021 top-box score is statistically significantly higher than the 2018 top-box score.*
▼ *Indicates the 2021 top-box score is statistically significantly lower than the 2018 top-box score.*
— *Indicates the 2021 top-box score is not statistically significantly different than the 2018 top-box score.*

Strengths

For AlohaCare QI, the top-box scores for the following five measures were statistically significantly higher than the QI Program aggregate:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Prior Authorization Process*
- *Adequate Access to Non-Formulary Drugs*
- *Access to Substance Abuse Treatment*

In addition, the top-box score for the following measure was statistically significantly higher in 2021 than in 2018:

- *Adequate Access to Non-Formulary Drugs*

Areas for Improvement

For AlohaCare QI, the top-box score for the following measure was lower than the QI Program aggregate, although no measure's top-box score was statistically significantly lower:

- *Adequate Network of Specialists*

In addition, the top-box scores for the following six measures were lower in 2021 than in 2018, although no measure's top-box score was statistically significantly lower:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Formulary*
- *Helpfulness of Service Coordinators*
- *Adequate Network of Specialists*
- *Availability of Mental Health Providers*

Encounter Data Validation

The following is a summary of findings from an assessment of AlohaCare QI's processes for collecting, adjudicating, managing, and submitting encounter data to the State. HSAG conducted a targeted encounter data IS assessment to examine the extent to which AlohaCare QI has appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. In collaboration with the MQD, HSAG developed questionnaires to gather information from AlohaCare QI on general approaches to, and specific procedures for, data processing, personnel responsible for data, data acquisition capabilities, and data monitoring processes. The IS assessment component of the study provided self-reported qualitative information from AlohaCare QI regarding its data processes. To conduct the administrative profile analysis, HSAG used various data sources including encounter data, member demographic/enrollment data, and provider data submitted by the MQD for the EDV study. HSAG examined encounters with dates of service from January 1, 2019, through December 31, 2019, with at least six months of run-out. The data presented below highlight results for AlohaCare QI.

Findings

Targeted Encounter Data Information Systems Assessment

The IS assessment of AlohaCare QI's questionnaire responses demonstrated that AlohaCare QI has the capacity to collect, process, and transmit to the MQD claims and encounter data meeting established quality specifications. AlohaCare QI provided descriptions of the roles of internal personnel and departments as well as software systems and external vendors employed for activities such as claims and adjudication, and provider and member information verification; management of TPL information; and processing the encounter data reconciliation and rate files. AlohaCare QI also provided descriptions of a

robust process as to how it monitors accuracy, completeness, and timeliness of encounter data submitted by its vendor(s) and/or provider(s).

The IS assessment also revealed that while AlohaCare QI's average rejection rate for claims rejected by the MQD's EDI translator was low, the average rejection rate for encounters that were rejected by the MQD's MMIS was high. Of note, these rejection rate patterns were similar to other health plans, where the high MMIS rejection rates were mostly due to provider-related issues (e.g., provider enrollment/activation). At the time of the questionnaire response submission, the MQD acknowledged that it was in the process of transitioning provider data flows from the previous process to a new provider system, HOKU. This new provider system is expected to alleviate the provider-related issues encountered during data processing, which have resulted in the submitted encounter data being rejected.

Administrative Profile

Figure 3-1 shows the percentage of accepted encounters with valid values for each listed data element. HSAG considered rates of valid values of 99 percent to be sufficiently high with no cause for concern. This criterion is not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-1—Key Encounter Data Elements, AlohaCare QI

Field	Professional	Inpatient	Long-Term Care	Hospital Outpatient	Pharmacy
Member ID	99.9%	99.5%	>99.9%	>99.9%	>99.9%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	100.0%	100.0%	100.0%	100.0%	—
Detail First Date of Service	—	100.0%	>99.9%	>99.9%	—
Detail Last Date of Service	—	100.0%	>99.9%	>99.9%	—
Paid/Adjudication Date	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	93.6% ✗	NR ✗	NR ✗	NR ✗	99.7%
Rendering Provider ID	98.9% ✗	92.3% ✗	94.6% ✗	94.0% ✗	98.8% ✗
Primary Diagnosis Code	99.3%	100.0%	100.0%	100.0%	—
Secondary Diagnosis Code(s)	>99.9%	100.0%	100.0%	100.0%	—
CPT/HCPCS Code(s)	>99.9%	100.0%	100.0%	100.0%	—
Surgical Procedure Code(s)	—	100.0%	NR ✗	100.0%	—
Revenue Code	—	100.0%	99.9%	>99.9%	—
NDC	—	—	—	—	99.7%
Number of applicable data elements evaulated for validity	9	13	12	13	6
Percentage of data elements meeting 99% or greater validity	77.8%	84.6%	83.3%	84.6%	83.3%

Note: NR indicates the rate is not reportable due to no denominator claims; Em-dash ("—") indicates the data element does not pertain to the claim type; ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code.

To assess AlohaCare QI's performance of encounter payment timeliness, HSAG compared the percentage of encounters paid within a typical lag of 180 days (approximately six months) to general standards based on HSAG's experience as an EQRO. HSAG considered a payment rate of 95 percent or greater as sufficient enough to minimally impact downstream analysis, while rates below 90 percent signified areas for improvement. HSAG considered rates between 90 and 95 percent as acceptable—that is, neither an area of particular concern nor especially high. These standards are not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plans accountable or for CAPs.

Figure 3-2 shows the percentage of encounters paid within 180 days (approximately six months) from the last date of service for AlohaCare QI.

Figure 3-2—Percentage of Encounters Paid Within 180 Days, AlohaCare QI

	AlohaCare QI
Professional	89.5% ✗
Inpatient	89.8% ✗
Hospital Outpatient	87.9% ✗
Long-Term Care	94.8%
Pharmacy	99.4% ✓

✓ Greater than 95 percent paid within 180 days;
✗ Below 90 percent paid within 180 days.

Strengths

- The IS review revealed that AlohaCare QI has a relatively robust process for monitoring the accuracy, completeness, and timeliness of encounter data. AlohaCare QI continually worked and provided education to its providers to ensure accurate claims submissions and created various reports to assess encounter data quality, completeness, and timeliness.
- Overall, more than 80 percent of the data elements analyzed for all encounter types, except professional encounters, met the validity criteria.
- Nearly all pharmacy encounters (99.4 percent) were paid within 180 days from the last date of service.

Areas for Improvement

- Encounter lag for three encounter types was relatively low: professional, inpatient, and hospital outpatient. Less than 90 percent of these encounters were paid within a typical lag time of 180 days (approximately six months) as shown in Figure 3-2.

– Impact: Timely payment and submission of encounters following their date of service is critical for conducting accurate analyses both for the MQD and its subcontractors, such as actuaries, its EQRO, and independent evaluators for Section 1115 and Section 1915 (c) demonstrations.[3-12] Lags in data submission could result in delayed analysis or incomplete or biased results.

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

Since AlohaCare QI performed well during the 2020 compliance review, only two corrective action items needed to be completed in 2021. Encompassing the Provider Selection and Subcontracts and Delegation standards, AlohaCare QI took the necessary steps to ensure its subcontracts included a complete and accurate set of requirements and that its provider selection policies and procedures were updated and executed to address identified deficiencies.

The EDV activities revealed that AlohaCare QI implemented a relatively robust process for monitoring the accuracy, completeness, and timeliness of encounter data. Additionally, more than 80 percent of the data elements analyzed for all encounter types, except professional encounters, met the validity criteria. One area for improvement is related to encounter payment timeliness. Encounter lag for three encounter types was relatively low: professional, inpatient, and hospital outpatient. Less than 90 percent of these encounters were paid within a typical lag time of 180 days.

Results from the compliance review and EDV activities demonstrated that AlohaCare QI continued to show that it had systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. However, despite a strong infrastructure, health plan performance indicators and member satisfaction scores related to access to care were generally below the national Medicaid 50th percentile.

Overall, more than three-quarters (90.3 percent) of AlohaCare QI's measure rates fell below the 50th percentile across all domains, with more than half (58.1 percent) falling below the 25th percentile. While

[3-12] For example, the MQD currently has two active and approved Section 1115 waivers and one active and approved Section 1915 (c) waiver demonstration. CMS expects states to provide an interim evaluation report one year prior to the end of the Section 1115 waiver demonstration that consists of current findings in order to inform the decision on demonstration renewal.

some measures showed improvement from HEDIS MY 2019, AlohaCare QI's performance suggested several areas in need of improvement including the Children's Preventive Health, Women's Health, Care for Chronic Conditions, and Behavioral Health domains. Only two of AlohaCare QI's measure rates met the MQD Quality Strategy targets.

AlohaCare QI's CAHPS results illustrated mixed results regarding member satisfaction. All four Global Rating measure rates in 2021 were at or above the 2020 NCQA child Medicaid national average. This is an improvement from the 2019 rates in which only one Global Rating measure rate was at or above the national average. While none of the measures scored statistically significantly lower in 2021 than in 2019, four measure rates were below the 25th percentile and scored below the 2020 NCQA child Medicaid national averages, *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Customer Service*. These results indicate the need for AlohaCare QI to implement improvement strategies to ensure members have high-quality care and timely access to care.

Similarly, AlohaCare QI's Provider Survey results demonstrated both positive results and areas for improvement. AlohaCare QI's providers expressed significantly higher satisfaction with the adequacy of access to non-formulary drugs than reported in 2018. Moreover, the top-box scores for five measure rates were statistically significantly higher than the QI Program aggregate rates. However, providers noted dissatisfaction with the adequacy of access to specialists with the top-box score for this measure falling below the QI Program aggregate. In addition, the top-box scores for six measures were lower in 2021 than in 2018, indicating that AlohaCare QI has several areas on which to focus improvement efforts.

Finally, AlohaCare QI completed and submitted Module 4 and Module 5 for the *Improving Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness* PIPs. Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. AlohaCare QI was successful in achieving desired outcomes for the *Follow-Up After Hospitalization for Mental Illness* PIP. The health plan met the SMART Aim goal, and the tested intervention could be linked to the demonstrated improvement. HSAG assigned the PIP a level of *High Confidence*. For the *Improving Adolescent Well-Care Visits* PIP, the health plan met the SMART Aim goal. Although it appears that one of the interventions has the potential to result in improvement, it could not be clearly linked to improvement in the SMART Aim measure rate. HSAG assigned the PIP a level of *Low Confidence*. These results suggest that AlohaCare QI continues to have opportunities for improvement in executing the PIP process but shows an ability to appropriately apply key quality improvement principles.

Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

Compliance Monitoring Review

The 2021 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2020 review.

Findings

Table 3-12 presents the scores from HSAG's 2020 compliance review, the number of CAPs required, and the results of the 2021 follow-up reviews of HMSA QI.

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

Standard #	Standard Name	2020 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2021 Final Follow-Up Review Score
I	Provider Selection	100%	0	NA	**100%**
II	Subcontracts and Delegation	100%	0	NA	**100%**
III	Credentialing	99%	1	1	**100%**
IV	Quality Assessment and Performance Improvement	100%	0	NA	**100%**
V	Health Information Systems	100%	0	NA	**100%**
VI	Practice Guidelines	100%	0	NA	**100%**
VII	Program Integrity	95%	1	1	**100%**
VIII	Enrollment and Disenrollment	100%	0	NA	**100%**
	Totals	**99%**	**2**	**2**	**100%**

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

Strengths

Since HMSA QI performed well during the 2020 compliance review, only two corrective action items needed to be completed in 2021. To address the *Credentialing* standard deficiency, HMSA QI updated its recredentialing workflow and added edits in its credentialing system to flag incomplete recredentialing files to ensure that organizational providers submit a recredentialing application. To address the *Program Integrity* standard deficiency, HMSA QI updated its written process document to ensure that HMSA QI and its subcontractors 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.

Areas for Improvement

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

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

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

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. This was a recommendation in the prior year as well.

HMSA QI passed MRRV in the prior year, and its MRR processes did not significantly change; therefore, HMSA QI was not required to submit a convenience sample. MRRV was conducted for the following measures and corresponding measure groups as well as all medical record exclusions, and all records passed the validation without any critical issues:

- Group A: Biometrics (BMI, BP) & Maternity—*Controlling High Blood Pressure*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 10*
- Group F: Exclusions—All Medical Record Exclusions

Excluding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for ages 65 and older, all QI measures that HMSA QI was required to report were determined to be *Reportable*. A status of *NA (*i.e., *Small Denominator)* was assigned for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for ages 65 and older. HMSA QI followed the required specifications, but the denominator was too small to report a valid rate.

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. The one rate in this domain that could be compared to national benchmarks ranked at or above the 75th percentile. All three rates for the non-HEDIS *Heart Failure Admission Rate* measure demonstrated a relative decline (i.e., improvement) of more than 35 percent. One measure in this domain had an MQD Quality Strategy target (i.e., *Heart Failure Admission Rate—Total),* and HMSA QI met the target for HEDIS MY 2020.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Heart Failure Admission Rate*				
18–64 Years	37.13	21.52	-42.04%	NC
65 Years and Older	97.10	63.03	-35.09%	NC
Total	40.14	23.84	-40.61%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	9.26%	7.99%	-13.71%	★★★★
Expected Readmissions—Total	—	9.57%	—	NC
*Index Total Stays—O/E Ratio—Total**	0.92	0.83	-9.27%	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Children's Preventive Health Performance Measure Results

HMSA QI's Children's Preventive Health performance measure results are shown in Table 3-14. The *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures were new HEDIS measures; therefore, there were no prior year rates to compare to and no available benchmarks. Of note, three of the *Childhood Immunization Status* rates ranked at or above the 75th percentile, and five rates ranked at or above the 50th percentile. Conversely, three of the *Childhood Immunization Status* rates fell below the 25th percentile. One measure in this domain had an MQD Quality Strategy target for HEDIS MY 2020 (i.e., *Childhood Immunization Status—Combination 3)*, and HMSA QI did not meet the established target.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Child and Adolescent Well-Care Visits[1]				
3–11 Years	—	55.78%	—	NC
12–17 Years	—	52.69%	—	NC
18–21 Years	—	27.22%	—	NC

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Total	—	50.26%	—	NC
Childhood Immunization Status				
Combination 2	—	71.29%	—	★★
Combination 3	65.94%	68.61%	4.05%	★★
Combination 4	—	66.91%	—	★★
Combination 5	—	56.20%	—	★
Combination 6	—	49.15%	—	★★★★
Combination 7	—	55.23%	—	★
Combination 8	—	48.91%	—	★★★★
Combination 9	—	41.36%	—	★★★
Combination 10	—	41.12%	—	★★★
DTaP	74.21%	76.89%	3.61%	★★
Hepatitis A	—	86.37%	—	★★★
Hepatitis B	80.29%	82.24%	2.43%	★
HiB	87.59%	89.29%	1.94%	★★★
Influenza	—	58.64%	—	★★★★
IPV	83.21%	87.10%	4.67%	★★
MMR	88.81%	89.54%	0.82%	★★★
Pneumococcal Conjugate	75.67%	76.40%	0.96%	★★
Rotavirus	—	70.32%	—	★★
VZV	87.35%	87.35%	0.00%	★★
Well-Child Visits in the First 30 Months of Life[1]				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	—	67.17%	—	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	78.88%	—	NC

[1] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.

** A lower rate indicates better performance.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

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 MY 2020, and one rate demonstrated a relative improvement of more than 29 percent; however, one of these rates ranked below the 25th percentile, and one ranked below the 50th percentile. Additionally, one rate reported a relative decline of more than 5 percent; however, the reported rate still met or exceeded the 50th percentile. Three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2020, and HMSA QI met the established target for all three rates.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Cervical Cancer Screening[1]				
Cervical Cancer Screening	68.13%	64.17%	-5.81%	★★★
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	77.62%	83.45%	7.51%	★
Postpartum Care	55.72%	72.02%	29.25%	★★

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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*
MY 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

HMSA QI's Care for Chronic Conditions performance measure results are shown in Table 3-16. Three measure rates that could be compared to national benchmarks ranked at or above the 50th percentile, and the other measure rate fell below the 25th percentile. MY 2020 represented the first year for reporting the non-HEDIS measure *Concurrent Use of Opioids and Benzodiazepines*; therefore, no prior year's rate is presented. Five measure rates[3-13] within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2020, and HMSA QI met the target for two of these measures: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *HbA1c Control (<8.0%)*.

[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)*.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing[2]	85.40%	82.73%	-3.13%	★
*HbA1c Poor Control (>9.0%)**[2]	40.39%	34.55%	-14.46%	★★★
HbA1c Control (<8.0%)[2]	47.69%	53.77%	12.75%	★★★
Eye Exam (Retinal) Performed[2]	66.91%	63.26%	-5.46%	★★★
Blood Pressure Control (<140/90 mm Hg)[1]	—	57.42%	—	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	—	14.50%	—	NC
65 Years and Older	—	9.30%	—	NC
Total	—	14.24%	—	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, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.
[2] Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Behavioral Health Performance Measure Results

HMSA QI's Behavioral Health performance measure results are shown in Table 3-17. The *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up—Total* and *30 Day Follow-Up—Total* measure rates demonstrated a relative increase. One measure rate that could be compared to national benchmarks ranked at or above the 75th percentile, four rates ranked at or above the 50th percentile, and one measure rate fell below the 50th percentile. MY 2020 represented the first year for reporting the non-HEDIS measures *Screening for Depression and Follow-Up Plan* and *Use of Pharmacotherapy for Opioid Use Disorder*; therefore, no prior years' rates are presented. Two measure rates[3-14] within this

[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*.

domain were associated with an MQD Quality Strategy target for HEDIS MY 2020, and HMSA QI met or exceeded the established targets for both measure rates.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—6–17 Years	—	47.34%	—	★★★
7-Day Follow-Up—18–64 Years	—	40.20%	—	★★★★
7-Day Follow-Up—65+ Years	—	NA	—	NC
7-Day Follow-Up—Total	38.69%	41.80%	8.04%	★★★
30-Day Follow-Up—6–17 Years	—	67.46%	—	★★
30-Day Follow-Up—18–64 Years	—	58.80%	—	★★★
30-Day Follow-Up—65+ Years	—	NA	—	NC
30-Day Follow-Up—Total	59.64%	60.86%	2.05%	★★★
Screening for Depression and Follow-Up Plan				
12–17 Years	—	47.25%	—	NC
18–64 Years	—	23.96%	—	NC
65 Years and Older	—	25.38%	—	NC
18 Years and Older	—	24.04%	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	—	50.68%	—	NC
Buprenorphine	—	32.74%	—	NC
Oral Naltrexone	—	1.63%	—	NC
Long-Acting, Injectable Naltrexone	—	0.20%	—	NC
Methadone	—	18.00%	—	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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

Conclusions and Recommendations

Based on HSAG's analyses of HMSA QI's 33 measure rates comparable to benchmarks, 18 measure rates (54.5 percent) ranked at or above the 50th percentile, with five of these rates (15.2 percent) ranking at or above the 75th percentile, indicating positive performance in appropriate screening for cervical cancer, timely receipt of childhood immunizations, appropriate monitoring of eye exams and control of HbA1c levels for diabetic members, and appropriate monitoring of members who were hospitalized for a mental health illness. Additionally, HMSA QI met eight of the MQD Quality Strategy targets for HEDIS MY 2020.

Conversely, 15 of HMSA QI's measure rates comparable to benchmarks (45.5 percent) fell below the 50th percentile, with five rates (15.2 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across most 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:

- Children's Preventive Health
  - *Childhood Immunization Status—Combination 5, Combination 7,* and *Hepatitis B*
- Women's Health
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care—HbA1c Testing*

Validation of Performance Improvement Projects

For validation year 2021, HMSA QI completed and submitted Module 4 and Module 5 for the *Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness* PIPs. These PIPs were initiated in CY 2019, and this is the final validation.

Findings

Module 4: Plan-Do-Study-Act

Adolescent Well-Care Visits

HMSA QI tested one intervention, Targeted member incentive and education, for the PIP and documented that the intervention was delayed due to COVID-19. During the check-ins, HSAG noted errors in the reported data for the SMART Aim measure and the denominator description for the intervention effectiveness measure. The health plan addressed HSAG's feedback in the final Module 4 submission; however, this submission contained additional data discrepancies. HMSA QI reported that the intervention testing time period was three months and, based on the data, only 46 of the 784

members who received the intervention completed an adolescent well-care visit and received the incentive. The intervention was not as effective as the health plan had hoped it would be. The health plan decided to continue testing the intervention.

Follow-Up After Hospitalization for Mental Illness

HMSA QI tested two interventions for the PIP:

1. Transitional Care Management: The health plan tested the intervention from July 2020 to January 2021. During this intervention, the health plan helped members schedule a behavioral health provider follow-up appointment while each member was inpatient and prior to discharge from Castle Medical Center. During the check-ins, HSAG noted errors in the reported data for the SMART Aim measure and opportunity for improving the intervention effectiveness measure to better understand the effectiveness of the intervention. The health plan addressed HSAG's feedback in the final Module 4 submission. Based on the intervention effectiveness measure data, the health plan reported improved compliance in members receiving the intervention. The health plan decided to expand the intervention to two additional facilities and continue testing beyond the SMART Aim end date.
2. Service Coordination: The health plan tested the intervention from July 2020 to January 2021. During this intervention, the health plan contacted members who were admitted inpatient for mental illness within two days of discharge to enroll them in the Service Coordination Program. During the review of the intervention plan, HSAG noted an opportunity for improving the intervention effectiveness measure to better understand the effectiveness of the intervention. The health plan addressed HSAG's feedback in the final Module 4 submission. Based on the reported data, it appears that a total of 15 members were enrolled, six of whom had a compliant follow-up after hospitalization visit. The health plan decided to continue testing the intervention beyond the SMART Aim end date.

Module 5: PIP Conclusions

HSAG organized and analyzed HMSA QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. The validation findings for HMSA QI's PIPs are presented in Table 3-18 and Table 3-19.

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Improving Adolescent Well-Care Visits

Table 3-18—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
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%.	38%	41%	44.08%	*Low Confidence*

Based on the SMART Aim run chart, the data points were above the goal until the intervention started in October 2020. After the intervention began, the SMART Aim measure result declined to below the baseline. The highest SMART Aim rate was 44.08 percent for the 12-month period of November 1, 2019, through October 31, 2020. The SMART Aim goal was achieved; however, the intervention tested could not be linked to the improvement. Therefore, HSAG assigned the PIP a score of *Low Confidence.*

HMSA QI documented the following lessons learned for the *Adolescent Well-Care Visits* PIP:

- The lack of available pediatric providers may have affected the rate of Kauai adolescent well-care visits.
- COVID-19 could have also been a factor in deterring appointment scheduling.
- During the intervention, the health plan updated the member file for incentive program eligibility monthly. To add eligible members to the program as quickly as possible, HMSA QI plans to update the member file weekly rather than monthly.
- HMSA QI will work on deploying the incentive program earlier in the year rather than later. This may provide members ample time to schedule and complete visits.

Follow-Up After Hospitalization for Mental Illness

Table 3-19—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
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 seven days after discharge from 34.72% to 37.72%."	34.72%	37.72%	39.65%	*Confidence*

Based on the SMART Aim data, the results exceeded the goal of 37.72 percent for seven months. Six of these months were after the interventions began. HSAG assigned the PIP a score of *Confidence*.

HMSA QI documented the following lessons learned for the *Follow-Up After Hospitalization for Mental Illness* PIP:

- Buy-in from the facility and day-to-day staff was integral in successful partnership with the project team.
- Telehealth and telephonic appointments increased the ability for members to attend their seven-day follow-up visits.

Strengths

- For the *Follow-Up After Hospitalization for Mental Illness* PIP, the health plan met the SMART Aim goal, and the tested interventions could be linked to improvement in the SMART Aim measure rate.
- Telehealth and telephonic appointments increased the ability of members to attend their seven-day follow-up visits.
- The health plan addressed HSAG's feedback during the PIP check-ins.

Areas for Improvement

- HMSA QI was not successful in achieving desired outcomes for the *Improving Adolescent Well-Care Visits* PIP. The tested intervention could not be linked to the demonstrated improvement.
- The health plan should ensure that it is reaching an adequate number of members with an intervention to be able to reach the SMART Aim goal.
- The interventions should be tested in a timely manner to allow adequate time for the targeted members to engage for a desired outcome and make appropriate revisions to the interventions as needed.
- The reported data continued to contain errors in the PIP submissions.

Recommendations

- When planning an intervention for testing, HMSA QI should think proactively about the potential barriers to testing the selected interventions. This may help ensure testing of interventions in a timely manner without delays.
- HMSA QI should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.
- HMSA QI should adopt/adapt plan-wide the interventions that are deemed successful after continued testing.
- HMSA QI should continue its efforts to improve the performance on the PIP topics beyond the SMART Aim end date.

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

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

Findings

Table 3-20 presents the 2021 percentage of top-box responses for HMSA QI compared to the 2020 NCQA child Medicaid national averages and the corresponding 2019 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 2020 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-17]

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

Measure	2019 Scores	2021 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	74.1%	76.1%	★★★★
Rating of All Health Care	72.3%	72.0%	★★
Rating of Personal Doctor	78.1%	82.9%	★★★★
Rating of Specialist Seen Most Often	74.5%+	68.6%+	★
Composite Measures			
Getting Needed Care	82.0%	84.2%	★★
Getting Care Quickly	87.0%	82.9%	★
How Well Doctors Communicate	96.3%	95.2%	★★
Customer Service	86.4%+	87.2%+	★★
Individual Item Measure			
Coordination of Care	80.8%+	82.3%+	★

Cells highlighted in yellow represent scores that are at or above the 2020 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2020 NCQA child Medicaid national averages.
▲ Indicates the 2021 score is statistically significantly higher than the 2019 score.
▼ Indicates the 2021 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

3-15 The adult population was last surveyed in 2020; therefore, the 2021 child CAHPS scores are compared to the corresponding 2019 scores.

3-16 National Committee for Quality Assurance. *HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2020.

3-17 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020*. Washington, DC: NCQA, September 2020.

Strengths

For HMSA QI's child Medicaid population, the following three measures met or exceeded the 2020 NCQA child Medicaid national averages:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*

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

Areas for Improvement

HSAG performed an analysis of the 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 3-21 provides a summary of the key drivers identified for HMSA QI.

Table 3-21—HMSA QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Child received appointment for a checkup or routine care as soon as needed	✓		
Ease of getting the care, tests, or treatment the child needed	✓	✓	✓
The customer service area for the child's health plan gave the parent/caretaker the information or help needed	✓	✓	N/A
Ease of filling out forms from the child's health plan	✓	✓	N/A

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

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

- Respondents reported that when their child did not need care right away, they did not obtain an appointment for healthcare as soon as they thought they needed.
- 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 an area for improvement in quality of care for HMSA QI:

- Respondents reported that customer service area of their child's health plan did not always give them the information or help they needed.
- Respondents reported that forms from their child's health plan were often not easy to fill out.

Provider Survey

The following is a summary of the Provider Survey performance highlights for HMSA QI.

Findings

Table 3-22 presents the 2021 top-box scores compared to the QI Program aggregate and the corresponding 2018 top-box scores, where applicable, on the six domains of satisfaction for HMSA QI.[3-18]

Table 3-22—Provider Survey Results for HMSA QI

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	36.2%	32.4%	27.6%	↑	—
Timeliness of Claims Payments	56.6%	55.7%	47.0%	↑	—
Providing Quality Care					
Formulary	25.1%	18.1%	14.9%	↑	—
Prior Authorization Process	27.1%	23.0%	17.2%	↑	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	21.2%	20.3%	22.2%	—	—
Service Coordinators					
Helpfulness of Service Coordinators	33.0%	31.1%	31.8%	—	—
Specialists					
Adequate Network of Specialists	40.8%	37.0%	24.5%	↑	—

[3-18] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2021 Hawaii Provider Survey full report.

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
Availability of Mental Health Providers	25.5%	15.5%	13.6%	—	—
Substance Abuse					
Access to Substance Abuse Treatment	23.9%	20.8%	19.2%	↑	—

↑ *Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2021 top-box score is statistically significantly higher than the 2018 top-box score.*
▼ *Indicates the 2021 top-box score is statistically significantly lower than the 2018 top-box score.*
— *Indicates the 2021 top-box score is not statistically significantly different than the 2018 top-box score.*

Strengths

For HMSA QI, the top-box scores for the following six measures were statistically significantly higher than the QI Program aggregate:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Formulary*
- *Prior Authorization Process*
- *Adequate Network of Specialists*
- *Access to Substance Abuse Treatment*

Areas for Improvement

For HMSA QI, the top-box scores for the following two measures were lower than the QI Program aggregate, although no measure's top-box score was statistically significantly lower:

- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Service Coordinators*

In addition, the top-box score for every measure was lower in 2021 than in 2018, although no measure's top-box score was statistically significantly lower.

Encounter Data Validation

The following is a summary of findings from an assessment of HMSA QI's processes for collecting, adjudicating, managing, and submitting encounter data to the State. HSAG conducted a targeted encounter data IS assessment to examine the extent to which HMSA QI has appropriate system

documentation and the infrastructure to produce, process, and monitor encounter data. In collaboration with the MQD, HSAG developed questionnaires to gather information from HMSA QI on general approaches to, and specific procedures for, data processing, personnel responsible for data, data acquisition capabilities, and data monitoring processes. The IS assessment component of the study provided self-reported qualitative information from HMSA QI regarding its data processes. To conduct the administrative profile analysis, HSAG used various data sources including encounter data, member demographic/enrollment data, and provider data submitted by the MQD for the EDV study. HSAG examined encounters with dates of service from January 1, 2019, through December 31, 2019, with at least six months of run-out. The data presented below highlight results for HMSA QI.

Findings

Targeted Encounter Data Information Systems Assessment

The IS assessment of HMSA QI's IS questionnaire responses demonstrated that HMSA QI has the capacity to collect, process, and transmit to the MQD claims and encounter data meeting established quality specifications. HMSA QI provided descriptions of the roles of internal personnel and departments as well as software systems and external vendors employed for activities such as claims and adjudication, and provider and member information verification; management of TPL information; and processing the encounter data reconciliation and rate files. HMSA QI also provided descriptions of a relatively robust process as to how it monitors accuracy, completeness, and timeliness of encounter data submitted by its vendor(s) and/or provider(s).

The IS assessment also revealed that while HMSA QI's average rejection rate for claims rejected by the MQD's EDI translator was low, the average rejection rate for encounters that were rejected by the MQD's MMIS was high. Of note, these rejection rate patterns were similar to other health plans, where the high MMIS rejection rates were mostly due to provider-related issues (e.g., provider enrollment/activation). At the time of the questionnaire response submission, the MQD acknowledged that it is in the process of transitioning provider data flows from the previous process to a new provider system, HOKU. This new provider system is expected to alleviate the provider-related issues encountered during data processing, which have resulted in the submitted encounter data being rejected.

Administrative Profile

Figure 3-3 shows the percentage of accepted encounters with valid values for each listed data element. HSAG considered rates of valid values of 99 percent to be sufficiently high with no cause for This criterion is not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-3–Key Encounter Data Elements, HMSA QI

Field	Professional	Inpatient	Long-Term Care	Hospital Outpatient	Pharmacy
Member ID	99.8%	99.5%	99.5%	99.9%	>99.9%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	>99.9%	100.0%	100.0%	100.0%	—
Detail First Date of Service	—	100.0%	100.0%	100.0%	—
Detail Last Date of Service	—	100.0%	100.0%	100.0%	—
Paid/Adjudication Date	>99.9%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	93.8% ✗	NR ✗	NR ✗	NR ✗	99.7%
Rendering Provider ID	98.5% ✗	90.8% ✗	90.3% ✗	92.9% ✗	99.1%
Primary Diagnosis Code	99.3%	100.0%	100.0%	100.0%	—
Secondary Diagnosis Code(s)	>99.9%	100.0%	>99.9%	100.0%	—
CPT/HCPCS Code(s)	>99.9%	100.0%	100.0%	100.0%	—
Surgical Procedure Code(s)	—	100.0%	NR ✗	100.0%	—
Revenue Code	—	100.0%	100.0%	100.0%	—
NDC	—	—	—	—	99.9%
Number of applicable data elements evaulated for validity	9	13	12	13	6
Percentage of data elements meeting 99% or greater validity	77.8%	84.6%	83.3%	84.6%	100.0%

Note: NR indicates the rate is not reportable due to no denominator claims; Em-dash ("—") indicates the data element does not pertain to the claim type; ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code.

To assess HMSA QI's performance of encounter payment timeliness, HSAG compared the percentage of encounters paid within a typical lag of 180 days (approximately six months) to general standards based on HSAG's experience as an EQRO. HSAG considered a payment rate of 95 percent or greater as sufficient enough to minimally impact downstream analysis, while rates below 90 percent signified areas for improvement. HSAG considered rates between 90 and 95 percent as acceptable—that is, neither an area of particular concern nor especially high. These standards are not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-4 shows the percentage of encounters paid within 180 days (approximately six months) from the last date of service for HMSA QI.

Figure 3-4—Percentage of Encounters Paid Within 180 Days, HMSA QI

	HMSA QI
Professional	92.9%
Inpatient	98.6% ✓
Hospital Outpatient	99.4% ✓
Long-Term Care	99.2% ✓
Pharmacy	98.9% ✓

✓ Greater than 95 percent paid within 180 days;
✗ Below 90 percent paid within 180 days.

Strengths

- The IS review revealed that HMSA QI has a relatively robust process for monitoring the accuracy, completeness, and timelines of encounter data. HMSA QI uses its InStream editing and claims processing system software editing to validate accuracy and completeness. For timeliness, its claims processing system has an edit which identifies claims that are submitted more than one year after the date of service.
- Overall, more than 80 percent of the data elements analyzed for all encounter types, except professional claims, met the 99 percent validity criteria.
- Greater than 95 percent of inpatient, hospital outpatient, LTC, and pharmacy encounters were paid within 180 days from the last date of service.

Areas for Improvement

- Nearly half of the rendering/servicing provider NPIs in encounters were not found in the provider reference file. However, these providers only accounted for approximately 5 percent of all encounters, and Medicaid provider IDs were sufficiently found in the reference file. Using Medicaid IDs for analysis should yield valid results.

Overall Assessment of Quality, Accessibility, 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 six EQR activities. While follow-up on compliance monitoring review findings indicated that HMSA QI continued to

improve its operational foundation to support the quality, accessibility, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

Since HMSA QI performed well during the 2020 compliance review, only two corrective action items needed to be completed in 2021. Encompassing the Credentialing and Program Integrity standards, HMSA QI took the necessary steps to ensure its policies, procedures, workflows, and credentialing system were updated to address identified deficiencies.

The EDV activities revealed that HMSA QI implemented a relatively robust process for monitoring the accuracy, completeness, and timeliness of encounter data. Additionally, more than 80 percent of the data elements analyzed for all encounter types, except professional encounters, met the validity criteria. Additionally, greater than 95 percent of HMSA QI's inpatient, hospital outpatient, LTC, and pharmacy encounters were paid within 180 days from the last date of service.

Results from the compliance review and EDV activities demonstrated that HMSA QI continued to show that it had systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. However, despite a strong infrastructure, health plan performance indicators and member satisfaction scores related to access to care were generally below the national Medicaid 50th percentile.

Overall, nearly half (45.5 percent) of HMSA QI's measures fell below the 50th percentile across all domains. While some measures showed improvement from HEDIS MY 2019, HMSA QI's performance suggested several areas in need of improvement including the Children's Preventive Health, Women's Health, and Care for Chronic Conditions domains. While eight of the MQD Quality Strategy targets were met in HEDIS MY 2020, HMSA QI should focus improvement efforts on Children's Preventive Health, Women's Health, and Care for Chronic Conditions measures that fell below the 25th percentile.

HMSA QI's CAHPS results illustrated mixed results regarding member satisfaction. Three of the four Global Rating measure rates in 2021 were at or above the 2020 NCQA child Medicaid national average. While none of the measures scored statistically significantly lower in 2021 than in 2019, three measure rates were below the 25th percentile, *Rating of Specialist Seen Most Often, Getting Care Quickly,* and *Coordination of Care*. Additionally, six of the nine measure rates fell below the 2020 NCQA child Medicaid national averages. These results indicate the need for HMSA QI to implement improvement strategies to ensure members have high-quality care and timely access to care.

Similarly, HMSA QI's Provider Survey results demonstrated both positive results and areas for improvement. Top-box scores for six measures were statistically significantly higher than the QI Program aggregate rates. However, providers noted dissatisfaction with the adequacy of access to non-formulary drugs and helpfulness of health plan service coordinators, with top-box scores for these measures falling below the QI Program aggregate rate. In addition, the top-box scores for all measures were lower in 2021 than in 2018, indicating that HMSA QI has several areas on which to focus improvement efforts.

Finally, HMSA QI completed and submitted Module 4 and Module 5 for the *Improving Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness* PIPs. Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. HMSA QI was not successful in achieving desired outcomes for the *Improving Adolescent Well-Care Visits* PIP. The health plan met the SMART Aim goal; however, the tested intervention could not be linked to the demonstrated improvement. HSAG assigned the PIP a level of *Low Confidence*. For the *Follow-Up After Hospitalization for Mental Illness* PIP, the health plan met the SMART Aim goal, and the tested interventions could be linked to improvement in the SMART Aim measure rate. HSAG assigned the PIP a level of *Confidence*. These results suggest that HMSA QI continues to have opportunities for improvement in executing the PIP process but shows an ability to appropriately apply key quality improvement principles.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

Compliance Monitoring Review

The 2021 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2020 review.

Findings

Table 3-23 presents the scores from HSAG's 2020 compliance review, the number of CAPs required, and the results of the 2021 follow-up reviews of KFHP QI.

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

Standard #	Standard Name	2020 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2021 Final Follow-Up Review Score
I	Provider Selection	90%	1	1	**100%**
II	Subcontracts and Delegation	70%	6	6	**100%**
III	Credentialing	99%	1	1	**100%**
IV	Quality Assessment and Performance Improvement	100%	0	NA	**100%**
V	Health Information Systems	100%	0	NA	**100%**
VI	Practice Guidelines	100%	0	NA	**100%**
VII	Program Integrity	91%	2	2	**100%**
VIII	Enrollment and Disenrollment	100%	0	NA	**100%**
	Totals	**95%**	**10**	**10**	**100%**

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

Strengths

The 2020 compliance review revealed that KFHP QI had deficiencies in four of the eight standards reviewed. During 2021, KFHP QI completed 10 corrective action items to bring it into full compliance. To address the *Provider Selection* standard deficiency, KFHP QI updated its policies and procedures to ensure written notification is sent to providers if KFHP QI declines to include an individual provider or provider group in its network. In addition, KFHP QI informed staff members on the policy requirements and workflow processes. To address the *Subcontracts and Delegation* standard deficiencies, KFHP QI executed contract amendments with its subcontractors to ensure all required provisions were contained in the contracts. To address the *Credentialing* standard deficiency, KFHP QI revised the credentialing policy and procedure to ensure that State or CMS surveys are received and meet the health plan's quality guidelines for assessments or reassessments of non-accredited organizational providers and are conducted in lieu of KFHP QI conducting the on-site review. Finally, to address the *Program Integrity*

standard deficiencies, KFHP QI developed and implemented a policy to ensure that KFHP QI and its subcontractors 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 updated its provider manual and provider portal to inform its providers of the requirement to report overpayments to the health plan, how to return the overpayment, the requirement to return the overpayment within 60 days, and to notify the health plan in writing the reason for the overpayment.

Areas for Improvement

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

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

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

KFHP QI passed MRRV in the prior year, and its MRR processes did not significantly change; therefore, KFHP QI was not required to submit a convenience sample. MRRV was conducted for the following measures and corresponding measure groups as well as all medical record exclusions, and all records passed the validation process without any critical issues:

- Group A: Biometrics (BMI, BP) & Maternity—*Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Prenatal and Postpartum Care—Postpartum Care* and *Timeliness of Prenatal Care*
- Group D: Immunization & Other Screenings—*Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- Group F: Exclusions—All Medical Record Exclusions

Excluding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 6 to 17 years and 65 years and older stratifications, all QI measures that KFHP QI was required to report were determined to be *Reportable*. A status of *NA (*i.e., *Small Denominator)* was assigned for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 6 to 17 years and 65 years and older stratifications. KFHP QI followed the required specifications, but the denominator was too small to report a valid rate.

Because KFHP QI was found to be fully compliant during the NCQA HEDIS Compliance Audit, the auditors did not have any recommendations for KFHP QI.

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. The one rate in this domain that could be compared to national benchmarks ranked at or above the 75th percentile. All three rates for the non-HEDIS *Heart Failure Admission Rate* measure demonstrated a relative decline (i.e., improvement) of more than 5 percent. One measure in this domain had an MQD Quality Strategy target (i.e., *Heart Failure Admission Rate—Total*), and KFHP QI met or exceeded the established target for HEDIS MY 2020.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Heart Failure Admission Rate*				
18–64 Years	40.17	37.73	-6.07%	NC
65 Years and Older	126.31	107.76	-14.69%	NC
Total	46.13	42.72	-7.39%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	10.12%	8.15%	-19.47%	★★★★
Expected Readmissions—Total	—	9.98%	—	NC
*Index Total Stays—O/E Ratio—Total**	1.03	0.82	-20.69%	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Children's Preventive Health Performance Measure Results

KFHP QI's Children's Preventive Health performance measure results are shown in Table 3-25. The *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures were new HEDIS measures; therefore, there were no prior year rates to compare to and no available benchmarks. Overall, no relative rate declines were demonstrated. Of note, all of the *Childhood Immunization Status* rates ranked at or above the 50th percentile, 11 of which ranked at or above the 90th percentile. One measure in this domain had an MQD Quality Strategy target for HEDIS MY 2020

(i.e., *Childhood Immunization Status—Combination 3*), and KFHP QI met or exceeded the established target.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Child and Adolescent Well-Care Visits[1]				
3–11 Years	—	43.43%	—	NC
12–17 Years	—	34.36%	—	NC
18–21 Years	—	11.28%	—	NC
Total	—	35.54%	—	NC
Childhood Immunization Status				
Combination 2	—	82.50%	—	★★★★★
Combination 3	79.45%	80.42%	1.22%	★★★★★
Combination 4	—	80.42%	—	★★★★★
Combination 5	—	74.31%	—	★★★★★
Combination 6	—	68.89%	—	★★★★★
Combination 7	—	74.31%	—	★★★★★
Combination 8	—	68.89%	—	★★★★★
Combination 9	—	63.75%	—	★★★★★
Combination 10	—	63.75%	—	★★★★★
DTaP	82.51%	84.58%	2.51%	★★★★
Hepatitis A	—	90.42%	—	★★★★
Hepatitis B	90.82%	91.25%	0.47%	★★★
HiB	87.32%	88.19%	1.00%	★★★
Influenza	—	74.72%	—	★★★★★
IPV	90.52%	91.39%	0.96%	★★★
MMR	91.25%	91.25%	0.00%	★★★
Pneumococcal Conjugate	80.03%	82.64%	3.26%	★★★★
Rotavirus	—	81.94%	—	★★★★★
VZV	90.52%	90.56%	0.04%	★★★
Well-Child Visits in the First 30 Months of Life[1]				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	—	68.91%	—	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	84.62%	—	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, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Women's Health Performance Measure Results

KFHP QI's Women's Health performance measure results are shown in Table 3-26. All three measure rates that could be compared to national benchmarks met or exceeded the 75th percentile, one of which met or exceeded the 90th percentile. Three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2020, and KFHP QI met or exceeded all three of the established MQD Quality Strategy targets.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Cervical Cancer Screening[1]				
Cervical Cancer Screening	78.73%	74.90%	-4.86%	★★★★★
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	99.26%	93.60%	-5.70%	★★★★
Postpartum Care	87.62%	83.60%	-4.59%	★★★★

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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*
MY 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

KFHP QI's Care for Chronic Conditions performance measure results are shown in Table 3-27. The four measure rates that could be compared to national benchmarks ranked at or above the 25th percentile. Three rates in this domain reported a relative decrease of more than 8 percent. MY 2020 represented the first year for reporting the non-HEDIS measure *Concurrent Use of Opioids and Benzodiazepines*; therefore, no prior year's rate is presented. Five measure rates[3-19] within this domain were associated

[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)*.

with an MQD Quality Strategy target for HEDIS MY 2020, and KFHP QI did not reach the established targets for these measure rates.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing[2]	95.01%	86.88%	-8.56%	★★
*HbA1c Poor Control (>9.0%)**[2]	29.00%	41.05%	41.55%	★★
HbA1c Control (<8.0%)[2]	61.45%	49.04%	-20.20%	★★
Eye Exam (Retinal) Performed[2]	69.83%	58.42%	-16.34%	★★
Blood Pressure Control (<140/90 mm Hg)[1]	—	57.14%	—	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	—	8.44%	—	NC
65 Years and Older	—	2.94%	—	NC
Total	—	7.63%	—	NC

[1] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.

[2] Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.

** A lower rate indicates better performance.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

Behavioral Health Performance Measure Results

KFHP QI's Behavioral Health performance measure results are shown in Table 3-28. The two measure rates that could be compared to the prior year's rates showed a relative decline of more than 19 percent. Of the measures that could be compared to national benchmarks, one measure rate ranked at or above the 50th percentile, two rates met or exceeded the 75th percentile, and one rate ranked below the 50th percentile. MY 2020 represented the first year for reporting the non-HEDIS measures *Screening for Depression and Follow-Up Plan* and *Use of Pharmacotherapy for Opioid Use Disorder*; therefore, no prior years' rates are

presented. Two measure rates[3-20] within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2020, and KFHP QI met or exceeded both of the established targets.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—6–17 Years	—	NA	—	NC
7-Day Follow-Up—18–64 Years	—	38.54%	—	★★★★
7-Day Follow-Up—65+ Years	—	NA	—	NC
7-Day Follow-Up—Total	60.31%	43.70%	-27.54%	★★★★
30-Day Follow-Up—6–17 Years	—	NA	—	NC
30-Day Follow-Up—18–64 Years	—	55.21%	—	★★★
30-Day Follow-Up—65+ Years	—	NA	—	NC
30-Day Follow-Up—Total	73.28%	58.82%	-19.73%	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	—	2.07%	—	NC
18–64 Years	—	10.89%	—	NC
65 Years and Older	—	13.79%	—	NC
18 Years and Older	—	11.14%	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	—	44.21%	—	NC
Buprenorphine	—	33.68%	—	NC
Oral Naltrexone	—	1.05%	—	NC
Long-Acting, Injectable Naltrexone	—	0.00%	—	NC
Methadone	—	13.68%	—	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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

[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*.

Conclusions and Recommendations

Based on HSAG's analyses of KFHP QI's 31 measure rates comparable to benchmarks, 26 measure rates (83.9 percent) ranked at or above the 50th percentile, with 12 rates (38.7 percent) meeting or exceeding the 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met seven of the MQD Quality Strategy targets for HEDIS MY 2020.

Conversely, five of KFHP QI's measure rates comparable to benchmarks (16.1 percent) fell below the 50th percentile, suggesting that 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:

- Care for Chronic Conditions
  - *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%),* and *Eye Exam (Retinal) Performed*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

Validation of Performance Improvement Projects

For validation year 2021, KFHP QI completed and submitted Module 4 and Module 5 for the *Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness* PIPs. These PIPs were initiated in CY 2019, and this is the final validation.

Module 4: Plan-Do-Study-Act

Adolescent Well-Care Visits

KFHP QI tested two interventions for the PIP:

1. Adding Targeted Members to the Wait List: This intervention was tested for two months from June 1, 2020, through July 31, 2020. During the first check-in, HSAG noted that the health plan should prioritize the PIP efforts for the target member population of 12- to 21-year-olds. The health plan addressed HSAG's feedback in the final Module 4 submission. Based on the intervention testing data, adding members to the wait list did not yield a high rate of members getting scheduled for an adolescent well-care visit. The intervention was deemed ineffective and abandoned by the health plan.
2. Outreaching and Scheduling Members from the Outreach List Created from Well-Child Visit (WCV) Tool: This intervention was tested from August 1, 2020, through December 31, 2020. During the check-ins, HSAG noted possible errors in the reported data for the intervention effectiveness measure. Additionally, HSAG recommended that the health plan outreach more members to attain the SMART Aim goal by January 31, 2021. The health plan corrected data errors

in the final Module 4 submission. The health plan reported that the data indicated low outreach rates and the process was labor intensive; therefore, it abandoned the intervention.

Follow-Up After Hospitalization for Mental Illness

KFHP QI tested one intervention for the PIP, Live reminder call prior to scheduled hospital discharge appointment. The testing period began on May 15, 2020, and ended on January 31, 2021. During the check-ins, HSAG noted possible errors in the reported SMART Aim measure and provided recommendations to capture additional data to track the effectiveness of the interventions. Additionally, HSAG recommended that the health plan outreach more members to reach the SMART Aim goal by January 31, 2021. The health plan addressed HSAG's feedback in the final Module 4 submission. The health plan indicated that the intervention positively impacted the rate of completed appointments. When comparing the group who received the intervention against the group who did not, the overall data illustrated that the group who received and answered the live reminder call had a higher rate of completed hospital discharge appointments (76.67 percent) than the group who did not receive the intervention (64.71 percent). The health plan decided to adopt the intervention.

Module 5: PIP Conclusions

HSAG organized and analyzed KFHP QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. The validation findings for KFHP QI's PIPs are presented in Table 3-29 and Table 3-30.

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Improving Adolescent Well-Care Visits

Table 3-29—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By January 31, 2021, increase the percentage of completed adolescent well-care visits among QUEST Integration members ages 12–21 assigned to a primary care provider (PCP) at Waipio Clinic, from 45.46% to 48.42%.	45.46%	48.42%	42.06%	*Low Confidence*

Based on the SMART Aim data, the results did not achieve the goal of 48.42 percent. The highest SMART Aim rate reported was 42.06 percent. The SMART Aim goal was not achieved; therefore, HSAG assigned the PIP a score of *Low Confidence*.

KFHP QI documented the following lessons learned for the *Adolescent Well-Care Visits* PIP:

- Even though a member is added to the wait list, they may not receive an appointment until later, depending on when they are "due," when provider schedules are made available, and how many slots are available for the month the member is due.
- The member outreach process is labor intensive, requiring one person to create an outreach list and many others to manually document their individual outreach outcomes on a tracker as well as documenting in the electronic health record. Validating outreach outcomes is accomplished through manual chart reviews and is time consuming.

Follow-Up After Hospitalization for Mental Illness

Table 3-30—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
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.	68.14%	75.68%	75.64%	*Low Confidence*

Based on the SMART Aim data, the results did not achieve the goal of 75.68 percent. The highest SMART Aim rate reported was 75.64 percent for the 12-month period of June 1, 2019, through May 31, 2020. The SMART Aim goal was not achieved; therefore, HSAG assigned the PIP a score of *Low Confidence*.

KFHP QI documented the following lessons learned for the *Follow-Up After Hospitalization for Mental Illness* PIP:

- The health plan experienced a sharp increase in Medicaid enrollment by over 14,000 members, which began in April 2020 and continued throughout the entire intervention testing period. Engaging with and tracking members who have not been established with KFHP QI was difficult; some members preferred to follow up with their previous mental health practitioner.
- Live reminder calls had a positive impact on the rate at which members completed their appointments; however, to have a positive impact on the SMART Aim, the intervention would need to reach more members.
- The intervention was not useful for members with no contact information.

- Telehealth offers a convenient option for a follow-up visit for some members but is a challenge for those members without access to the necessary technology (computer, Internet access, phone, etc.), skills to manage the technology, or privacy needed to complete the telehealth visit.

Strengths

- For the *Follow-Up After Hospitalization for Mental Illness* PIP, the health plan deemed the Live reminder call prior to scheduled hospital discharge appointment intervention effective in improving the follow-up rates and therefore adopted the intervention.
- The health plan addressed HSAG's feedback during the PIP check-ins.

Areas for Improvement

- KFHP QI was not successful in achieving desired outcomes for the *Improving Adolescent Well-Care Visits* PIP. The tested interventions could not be linked to the demonstrated improvement.
- The health plan should ensure it is reaching an adequate number of members with an intervention to be able to reach the SMART Aim goal for the PIP.

Recommendations

- When planning an intervention for testing, KFHP QI should think proactively about the potential barriers to testing the selected interventions. This may help ensure testing of interventions in a timely manner without delays.
- KFHP QI should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.
- KFHP QI should continue its efforts to improve the performance on the PIP topics beyond the SMART Aim end date.

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

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

Findings

Table 3-31 presents the 2021 percentage of top-box responses for KFHP QI compared to the 2020 NCQA child Medicaid national averages and the corresponding 2019 scores.[3-21,3-22] Additionally, the

[3-21] The adult population was last surveyed in 2020; therefore, the 2021 child CAHPS scores are compared to the corresponding 2019 scores.

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

overall member experience ratings (i.e., star ratings) resulting from KFHP QI's top-box scores compared to NCQA's 2020 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-23]

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

.	2019 Scores	2021 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	71.9%	78.4% ▲	★★★★★
Rating of All Health Care	64.5%	82.1% ▲	★★★★★
Rating of Personal Doctor	79.3%	86.4% ▲	★★★★★
Rating of Specialist Seen Most Often	74.7%+	75.9%+	★★★★
Composite Measures			
Getting Needed Care	81.5%	86.6%	★★★
Getting Care Quickly	90.4%	88.8%	★★
How Well Doctors Communicate	96.2%	97.0%	★★★★
Customer Service	88.3%+	92.4%+	★★★★
Individual Item Measure			
Coordination of Care	84.8%	95.8%+ ▲	★★★★★

Cells highlighted in yellow represent scores that are at or above the 2020 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2020 NCQA child Medicaid national averages.
▲ Indicates the 2021 score is statistically significantly higher than the 2019 score.
▼ Indicates the 2021 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

Strengths

For KFHP QI's child Medicaid population, the following eight measures met or exceeded the 2020 NCQA child Medicaid national averages:

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

[3-23] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020.* Washington, DC: NCQA, September 2020.

- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Customer Service*
- *Coordination of Care*

In addition, the following four measures scored statistically significantly higher in 2021 than in 2019:

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Coordination of Care*

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

- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *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 *Rating of Health Plan* and *How Well Doctors Communicate* met or exceeded the 75th percentile.

Areas for Improvement

HSAG performed an analysis of the 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 3-32 provides a summary of the key drivers identified for KFHP QI.

Table 3-32—KFHP QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Ease of getting the care, tests, or treatment the child needed	✓	✓	✓
Child's personal doctor spent enough time with the child			✓
Child received appointment with a specialist as soon as needed	✓	✓	N/A

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Ease of filling out forms from the child's health plan	✓	✓	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 to and timeliness of care for KFHP QI:

- 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 an area for improvement in the quality of care for KFHP QI:

- Respondents reported that their child's personal doctor did not always spend enough time with them.
- Respondents reported that forms from their child's health plan were often not easy to fill out.

Provider Survey

The following is a summary of the Provider Survey performance highlights for KFHP QI.

Findings

Table 3-33 presents the 2021 top-box scores compared to the QI Program aggregate and the corresponding 2018 top-box scores, where applicable, on the six domains of satisfaction for KFHP QI.[3-24]

Table 3-33—Provider Survey Results for KFHP QI

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	54.2%	NA	27.6%	NA	NA
Timeliness of Claims Payments	42.9%	NA	47.0%	NA	NA

[3-24] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2021 Hawaii Provider Survey full report.

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
Providing Quality Care					
Formulary	56.4%	51.6%	14.9%	↑	—
Prior Authorization Process	30.6%	38.5%	17.2%	—	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	85.5%	87.5%	22.2%	↑	—
Service Coordinators					
Helpfulness of Service Coordinators	87.7%	77.4%	31.8%	↑	—
Specialists					
Adequate Network of Specialists	86.2%	78.8%	24.5%	↑	—
Availability of Mental Health Providers	44.6%	36.7%	13.6%	↑	—
Substance Abuse					
Access to Substance Abuse Treatment	50.9%	56.7%	19.2%	↑	—

↑ *Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2021 top-box score is statistically significantly higher than the 2018 top-box score.*
▼ *Indicates the 2021 top-box score is statistically significantly lower than the 2018 top-box score.*
— *Indicates the 2021 top-box score is not statistically significantly different than the 2018 top-box score.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

For KFHP QI, the top-box scores for the following six measures were statistically significantly higher than the QI Program aggregate:

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

In addition, the top-box scores for the following three measures were higher in 2021 than in 2018, although no measure's top-box score was statistically significantly higher:

- *Prior Authorization Process*
- *Adequate Access to Non-Formulary Drugs*
- *Access to Substance Abuse Treatment*

Areas for Improvement

For KFHP QI, the top-box scores for the following four measures were lower in 2021 than in 2018, although no measure's top-box score was statistically significantly lower:

- *Formulary*
- *Helpfulness of Service Coordinators*
- *Adequate Network of Specialists*
- *Availability of Mental Health Providers*

Encounter Data Validation

The following is a summary of findings from an assessment of KFHP QI's processes for collecting, adjudicating, managing, and submitting encounter data to the State. HSAG conducted a targeted encounter data IS assessment to examine the extent to which KFHP QI has appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. In collaboration with the MQD, HSAG developed questionnaires to gather information from KFHP QI on general approaches to, and specific procedures for, data processing, personnel responsible for data, data acquisition capabilities, and data monitoring processes. The IS assessment component of the study provided self-reported qualitative information from KFHP QI regarding its data processes. To conduct the administrative profile analysis, HSAG used various data sources including encounter data, member demographic/enrollment data, and provider data submitted by the MQD for the EDV study. HSAG examined encounters with dates of service from January 1, 2019, through December 31, 2019, with at least six months of run-out. The data presented below highlight results for KFHP QI.

Findings

Targeted Encounter Data Information Systems Assessment

The IS assessment of KFHP QI's IS questionnaire responses demonstrated that KFHP QI has the capacity to collect, process, and transmit to the MQD claims and encounter data meeting established quality specifications. KFHP QI provided descriptions of the roles of internal personnel and departments as well as software systems and external vendors employed for activities such as claims and adjudication, and provider and member information verification; management of TPL information; and processing the encounter data reconciliation and rate files. KFHP QI also provided descriptions of its

process as to how it monitors accuracy, completeness, and timeliness of encounter data submitted by its vendor(s) and/or provider(s).

The IS assessment also revealed that while KFHP QI's average rejection rate for claims rejected by the MQD's EDI translator was low, the average rejection rate for encounters that were rejected by the MQD's MMIS was high. Of note, these rejection rate patterns were similar to other health plans, where the high MMIS rejection rates were mostly due to provider-related issues (e.g., provider enrollment/activation). At the time of the questionnaire response submission, the MQD acknowledged that it is in the process of transitioning provider data flows from the previous process to a new provider system, HOKU. This new provider system is expected to alleviate the provider-related issues encountered during data processing, which have resulted in the submitted encounter data being rejected.

Administrative Profile

Figure 3-5 below shows the percentage of accepted encounters with valid values for each listed data element. HSAG considered rates of valid values of 99 percent to be sufficiently high with no cause for concern. This criterion is not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-5—Key Encounter Data Elements, KFHP QI

Field	Professional	Inpatient	Long-Term Care	Hospital Outpatient	Pharmacy
Member ID	99.7%	99.8%	100.0%	>99.9%	>99.9%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	100.0%	100.0%	100.0%	100.0%	—
Detail First Date of Service	—	100.0%	100.0%	100.0%	—
Detail Last Date of Service	—	100.0%	100.0%	100.0%	—
Paid/Adjudication Date	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	99.1%	NR ✗	NR ✗	NR ✗	100.0%
Rendering Provider ID	94.4% ✗	90.8% ✗	99.5%	87.9% ✗	99.2%
Primary Diagnosis Code	97.7% ✗	100.0%	100.0%	100.0%	—
Secondary Diagnosis Code(s)	>99.9%	100.0%	100.0%	100.0%	—
CPT/HCPCS Code(s)	>99.9%	100.0%	100.0%	100.0%	—
Surgical Procedure Code(s)	—	100.0%	NR ✗	NR ✗	—
Revenue Code	—	100.0%	100.0%	100.0%	—
NDC	—	—	—	—	99.2%
Number of applicable data elements evaulated for validity	9	13	12	13	6
Percentage of data elements meeting 99% or greater validity	77.8%	84.6%	91.7%	76.9%	100.0%

Note: NR indicates the rate is not reportable due to no denominator claims; Em-dash ("—") indicates the data element does not pertain to the claim type; ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code.

To assess KFHP QI's performance of encounter payment timeliness, HSAG compared the percentage of encounters paid within a typical lag of 180 days (approximately six months) to general standards based on HSAG's experience as an EQRO. HSAG considered a payment rate of 95 percent or greater as sufficient enough to minimally impact downstream analysis, while rates below 90 percent signified areas for improvement. HSAG considered rates between 90 and 95 percent as acceptable—that is, neither an area of particular concern nor especially high. These standards are not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-6 shows the percentage of encounters paid within 180 days (approximately six months) from the last date of service for KFHP.

Figure 3-6—Percentage of Encounters Paid Within 180 Days, KFHP QI

	KFHP QI
Professional	32.6% ✗
Inpatient	96.5% ✓
Hospital Outpatient	98.4% ✓
Long-Term Care	98.6% ✓
Pharmacy	58.8% ✗

✓ Greater than 95 percent paid within 180 days;
✗ Below 90 percent paid within 180 days.

Strengths

- Overall, more than 80 percent of the data elements analyzed for inpatient, LTC, and pharmacy encounter types met the validity criteria.
- Greater than 95 percent of all inpatient, hospital outpatient, and LTC encounters were paid within 180 days from the last date of service.

Areas for Improvement

- Based on the IS review, for timeliness, KFHP QI's claims processing system calculates the timeliness of the claim based on the date of service and the date it was received. KFHP QI should consider monitoring timeliness based on the date of service and payment date, as well as monitoring timeliness over time (e.g., week-to-week or month-to-month). Additionally, KFHP QI should consider adding more metrics to actively monitor encounter data completeness and accuracy before submitting files to the MQD. For example, KFHP QI could add current completeness metrics through highlighting abnormally high (e.g., due to duplicate records) or low (e.g., due to submission lags or incomplete data) volumes once trends have been established.

- At the time of analysis, KFHP QI did not submit pharmacy encounters with dates of service in August 2019. Gaps in pharmacy encounters will impact any subsequent analyses, such as performance measures, utilization, or costs.
- Professional and pharmacy encounters were paid inconsistently, resulting in low claims payment rates at 180 days following the date of service. While KFHP QI is unique in that it operates its own provider network and is not dependent on timely payment, to the extent this lag impacts submission in the MQD's MMIS, encounters from KFHP QI would be incomplete for downstream analyses.

Overall Assessment of Quality, Accessibility, 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 six EQR activities. While the HEDIS measure results, CAHPS results, and Provider Survey results indicate a high level of performance on outcome and process measures, KFHP QI has the need for operational improvements to support the quality of, access to, and timeliness of care and service delivery to its members.

Although KFHP QI's performance during the 2020 compliance review revealed that the health plan had systems, policies, and staff in place to ensure appropriate structure and operations, 10 corrective action items were required to be implemented in 2021. Encompassing the *Provider Selection, Subcontracts and Delegation, Credentialing,* and *Program Integrity* standards, KFHP QI took the necessary steps to ensure its policies, procedures, and subcontracts were revised to address identified deficiencies.

The EDV activities revealed that KFHP QI could benefit from implementing additional processes for monitoring the accuracy, completeness, and timeliness of encounter data. While more than 80 percent of the data elements analyzed for inpatient, LTC, and pharmacy encounters met the validity criteria, professional and pharmacy encounters were paid inconsistently, resulting in low claims payment rates at 180 days following the date of service. Additionally, KFHP QI did not submit pharmacy encounters with dates of service in August 2019. Gaps in pharmacy encounters can impact subsequent analyses, such as performance measures, utilization, or costs, and highlight the need for more robust encounter data monitoring.

KFHP QI continued to show strong performance in quality, performance, and outcome measures. Overall, more than three-quarters (83.9 percent) of KFHP QI's measure rates ranked at or above the 50th percentile across all domains, with nearly two-thirds (64.5 percent) of the measure rates ranking at or above the 75th percentile. Conversely, less than 20 percent of KFHP QI's measure rates fell below the 50th percentile. KFHP QI's performance demonstrated a few areas for improvement, including the Care for Chronic Conditions and Behavioral Health domains. KFHP QI's measure rates met seven of the MQD Quality Strategy targets.

Similarly, KFHP QI's CAHPS results suggest strong member satisfaction, with four measure results being at or above the 90th percentile. Moreover, KFHP QI scored at or above the national average on eight of the nine measures. KFHP QI scored statistically significantly higher in 2021 relative to 2019 in the *Rating of Health Plan*, *Rating of All Health Care, Rating of Personal Doctor,* and *Coordination of Care* measures. *Getting Needed* Care was the only measure that fell below the 50th percentile and the 2020 NCQA child Medicaid national averages, indicating a potential concern for members receiving timely access to care.

In addition to comparatively high levels of satisfaction among members, KFHP QI's Provider Survey results also demonstrated high levels of satisfaction among providers across all domains. Top-box scores for six measure results were statistically significantly higher than the QI Program aggregate rates. KFHP scored lower in 2021 than in 2018 in the *Formulary, Helpfulness of Service Coordinators, Adequate Network of Specialists,* and *Availability of Mental Health Providers* measures, indicating that KFHP QI has room for improvement in the quality of and access to providers and services.

Finally, KFHP QI completed and submitted Module 4 and Module 5 for the *Improving Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness* PIPs. Both PIPs addressed CMS' requirements related to quality outcomes—specifically, access to, and timeliness of care and services. The validation findings suggest that KFHP QI was not successful in achieving the SMART Aim goal for either PIP. For the *Adolescent Well-Care Visits* PIP, both interventions were deemed ineffective and were abandoned. For the *Follow-Up After Hospitalization for Mental Illness* PIP, it appears that the tested intervention has the potential to demonstrate improvement; however, due to the low number of members impacted by the intervention, the SMART Aim goal could not be achieved. The health plan decided to adopt the intervention. HSAG assigned both PIPs a level of *Low Confidence*. These results suggest that KFHP QI continues to have opportunities for improvement in executing quality improvement processes.

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

Compliance Monitoring Review

The 2021 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2020 review.

Findings

Table 3-34 presents the scores from HSAG's 2020 compliance review, the number of CAPs required, and the results of the 2021 follow-up reviews of 'Ohana QI.

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

Standard #	Standard Name	2020 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2021 Final Follow-Up Review Score
I	Provider Selection	100%	0	NA	**100%**
II	Subcontracts and Delegation	95%	1	1	**100%**
III	Credentialing	100%	0	NA	**100%**
IV	Quality Assessment and Performance Improvement	100%	0	NA	**100%**
V	Health Information Systems	100%	0	NA	**100%**
VI	Practice Guidelines	100%	0	NA	**100%**
VII	Program Integrity	100%	0	NA	**100%**
VIII	Enrollment and Disenrollment	100%	0	NA	**100%**
	Totals	**99%**	**1**	**1**	**100%**

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

Strengths

Since 'Ohana QI performed well during the 2020 compliance review, only one corrective action item needed to be completed in 2021. To address the *Subcontracts and Delegation* standard deficiency, 'Ohana QI executed contract amendments with its Community Case Management Agencies (CCMAs) that included the correct timelines for medical record retention (10 years) in compliance with the State's health plan contract.

Areas for Improvement

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

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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

'Ohana QI passed MRRV in the prior year, and its medical record MRR processes did not significantly change; therefore, 'Ohana QI was not required to submit a convenience sample. MRRV was conducted for the following measures and corresponding measure groups as well as all medical record exclusions, and all records passed the validation without any critical issues:

- Group A: Biometrics (BMI, BP) & Maternity—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 10*
- Group F: Exclusions—All Medical Record Exclusions

Excluding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 6 to 17 years and 65 years and older stratifications, all QI measures that 'Ohana QI was required to report were determined to be *Reportable*. A status of *NA (*i.e., *Small Denominator)* was assigned for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 6 to 17 years and 65 years and older stratifications. 'Ohana QI followed the required specifications, but the denominator was too small to report a valid rate.

Because 'Ohana QI was found to be fully compliant during the NCQA HEDIS Compliance Audit, the auditors did not have any recommendations for 'Ohana QI.

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. The one rate in this domain that could be compared to national benchmarks ranked below the 50th percentile. All three rates for the non-HEDIS *Heart Failure Admission Rate* measure demonstrated a relative increase (i.e., decline) in performance, with two of the three rates demonstrating more than a 14 percent increase. This represents a decline in performance since lower rates for this measure indicate better performance. One measure in this domain had an MQD Quality Strategy target (i.e., *Heart Failure Admission Rate—Total),* and 'Ohana QI did not reach the established target for HEDIS MY 2020.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Heart Failure Admission Rate*				
18–64 Years	65.85	80.25	21.87%	NC
65 Years and Older	170.51	177.64	4.18%	NC
Total	84.80	97.31	14.75%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	10.53%	10.54%	0.09%	★★
Expected Readmissions—Total	—	11.62%	—	NC
*Index Total Stays—O/E Ratio—Total**	0.96	0.91	-5.53%	NC

** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Children's Preventive Health Performance Measure Results

'Ohana QI's Children's Preventive Health performance measure results are shown in Table 3-36. The *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures were new HEDIS measures; therefore, there were no prior year rates to compare to and no available benchmarks. All *Childhood Immunization Status* rates that were able to be compared to prior year's rates demonstrated a relative increase in performance, four of which reported a relative increase of more than 5 percent. Five of the *Childhood Immunization Status* rates ranked at or above the 50th percentile. Conversely, 14 rates fell below the 25th percentile. One measure in this domain had an MQD Quality Strategy target for HEDIS MY 2020 (i.e., *Childhood Immunization Status—Combination 3*), and 'Ohana QI did not reach the established target.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Child and Adolescent Well-Care Visits[1]				
3–11 Years	—	41.46%	—	NC
12–17 Years	—	38.11%	—	NC
18–21 Years	—	16.53%	—	NC

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Total	—	36.69%	—	NC
Childhood Immunization Status				
Combination 2	—	63.78%	—	★
Combination 3	56.43%	61.86%	9.62%	★
Combination 4	—	60.90%	—	★
Combination 5	—	54.49%	—	★
Combination 6	—	48.72%	—	★★★
Combination 7	—	53.53%	—	★
Combination 8	—	48.40%	—	★★★
Combination 9	—	43.91%	—	★★★
Combination 10	—	43.59%	—	★★★
DTaP	62.38%	66.03%	5.85%	★
Hepatitis A	—	76.92%	—	★
Hepatitis B	73.35%	76.92%	4.87%	★
HiB	74.92%	77.56%	3.52%	★
Influenza	—	56.41%	—	★★★
IPV	74.92%	78.21%	4.39%	★
MMR	74.92%	78.53%	4.82%	★
Pneumococcal Conjugate	60.50%	64.74%	7.01%	★
Rotavirus	—	63.14%	—	★
VZV	72.73%	78.85%	8.41%	★
Well-Child Visits in the First 30 Months of Life[1]				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	—	58.58%	—	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	66.38%	—	NC

[1] *Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

Women's Health Performance Measure Results

'Ohana QI's Women's Health performance measure results are shown in Table 3-37. Three measure rates that could be compared to national benchmarks ranked below the 50th percentile, with one of these measure rates falling below the 25th percentile. Three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2020. 'Ohana QI met or exceeded the established targets for two of the measure rates.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Cervical Cancer Screening[1]				
Cervical Cancer Screening	45.74%	47.20%	3.19%	★
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	86.92%	86.42%	-0.58%	★★
Postpartum Care	67.03%	72.83%	8.65%	★★

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
[1] *Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*
to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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

'Ohana QI's Care for Chronic Conditions performance measure results are shown in Table 3-38. Two rates in this domain reported a relative decrease of more than 6 percent. Two measure rates that could be compared to national benchmarks ranked at or above the 50th percentile, and two rates ranked below the 50th percentile, with one of these two measure rates falling below the 25th percentile. MY 2020 represented the first year for reporting the non-HEDIS measure *Concurrent Use of Opioids and Benzodiazepines*; therefore, no prior year's rate is presented. Five measure rates[3-25] within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2020, and 'Ohana QI met the target for one of these measure rates: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*.

[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)*.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing[2]	88.08%	82.73%	-6.07%	★
*HbA1c Poor Control (>9.0%)**[2]	39.66%	39.17%	-1.24%	★★
HbA1c Control (<8.0%)[2]	51.58%	53.28%	3.30%	★★★
Eye Exam (Retinal) Performed[2]	65.45%	61.31%	-6.33%	★★★
Blood Pressure Control (<140/90 mm Hg)[1]	—	59.61%	—	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	—	21.63%	—	NC
65 Years and Older	—	17.62%	—	NC
Total	—	20.76%	—	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, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.
[2] Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Behavioral Health Performance Measure Results

'Ohana QI's Behavioral Health performance measure results are shown in Table 3-39. The *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up—Total* and *30-Day Follow-Up—Total* indicators demonstrated a relative increase of more than 32 percent. Four measure rates that were compared to national benchmarks ranked at or above the 75th percentile, with two of these rates ranking above the 90th percentile. MY 2020 represented the first year for reporting the non-HEDIS measures *Screening for Depression and Follow-Up Plan* and *Use of Pharmacotherapy for Opioid Use Disorder*; therefore, no prior years' rates are presented. Two measure rates[3-26] within this domain were associated

[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.*

with an MQD Quality Strategy target for HEDIS MY 2020, and ‘Ohana QI met or exceeded the established targets for both measure rates.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—6–17 Years	—	NA	—	NC
7-Day Follow-Up—18–64 Years	—	51.27%	—	★★★★★
7-Day Follow-Up—65+ Years	—	NA	—	NC
7-Day Follow-Up—Total	33.19%	50.81%	53.09%	★★★★
30-Day Follow-Up—6–17 Years	—	NA	—	NC
30-Day Follow-Up—18–64 Years	—	73.42%	—	★★★★★
30-Day Follow-Up—65+ Years	—	NA	—	NC
30-Day Follow-Up—Total	53.28%	70.81%	32.90%	★★★★
Screening for Depression and Follow-Up Plan				
12–17 Years	—	14.22%	—	NC
18–64 Years	—	8.20%	—	NC
65 Years and Older	—	25.03%	—	NC
18 Years and Older	—	12.08%	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	—	46.33%	—	NC
Buprenorphine	—	16.61%	—	NC
Oral Naltrexone	—	1.60%	—	NC
Long-Acting, Injectable Naltrexone	—	0.00%	—	NC
Methadone	—	30.35%	—	NC

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

[1] *Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA’s recommendation for a break in trending.

NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

Conclusions and Recommendations

Based on HSAG's analyses of 'Ohana QI's 31 measure rates comparable to benchmarks, 11 measure rates (35.5 percent) ranked at or above the 50th percentile, with two measure rates (6.5 percent) ranking at or above the 90th percentile, indicating positive performance in follow-up visits for members who were hospitalized due to mental illness. Additionally, 'Ohana QI met five of the MQD Quality Strategy targets for HEDIS MY 2020.

Conversely, 20 measure rates comparable to benchmarks (64.5 percent) ranked below the 50th percentile, with 16 measure rates (51.6 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:

- Children's Preventive Health
  - *Childhood Immunization Status—Combination 2, Combination 3, Combination 4, Combination 5, Combination 7*, *DTaP*, *Hepatitis A, Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate, Rotavirus,* and *VZV*
- Women's Health
  - *Cervical Cancer Screening*
- Care for Chronic Conditions
  - *Comprehensive Diabetes Care—HbA1c Testing*

Validation of Performance Improvement Projects

For validation year 2021, 'Ohana QI completed and submitted Module 4 and Module 5 for the *Improving Rates for Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIPs. These PIPs were initiated in CY 2019, and this is the final validation.

Findings

Module 4: Plan-Do-Study-Act

Improving Rates for Adolescent Well-Care Visits

The health plan tested the following intervention during the PIP: Emphasizing and educating on the importance of a well-child visit to members and their parents/guardians through telephone outreach, by provider practice coordinators (PPCs) and/or service coordinators (SCs), 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. During the check-ins, HSAG recommended that the health plan consider addressing the top failure mode, the inability to contact the parent/guardians of the member in order to be able to successfully reach members for education on the importance of a

well-child visit. Additionally, HSAG also provided feedback on the intervention effectiveness measure data. In the final Module 4 submission, the health plan addressed HSAG's feedback on the intervention measure data; however, the success with member outreach continued to be low. The intervention was tested in two rounds; the first round was conducted from July 20, 2020, through August 21, 2020, and the second round was conducted from November 16, 2020, through December 11, 2020. The health plan had incomplete data for the first round of intervention testing; however, the health plan documented that, after the first round of testing, 91 of the 463 noncompliant members became *Adolescent Well-Care Visits (AWC)* measure compliant. After the second round of the intervention, wherein the data were manually tracked, the health plan reported that 45 of the 307 noncompliant members became *AWC* measure compliant. The health plan decided to continue testing the intervention beyond the SMART Aim end date.

Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge

The health plan tested the following intervention during this PIP: Ohana Qualified Mental Health Practitioner to provide a follow-up visit and short-term case management service within seven (7) days post inpatient discharge for mental illness. During the check-ins, HSAG provided feedback on the documentation of the intervention process. In the final Module 4 submission, the health plan addressed HSAG's feedback. This intervention was tested from January 2020 through the SMART Aim end date. At the beginning of the intervention testing period, the health plan faced COVID-19 pandemic, data, and staffing-related challenges; however, it appears that from July 2020 onwards, the health plan was able to carry out the intervention as planned. Telephonic follow-up visits were added as numerator-compliant follow-up visits in alignment with the HEDIS update. Based on the reported data collected during the intervention testing period, it appears that for 107 of the 172 total discharges, members had a compliant seven-day follow-up after hospitalization visit. The intervention was deemed effective, and the health plan decided to adopt the intervention.

Module 5: PIP Conclusions

HSAG organized and analyzed 'Ohana QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. The validation findings for 'Ohana QI's PIPs are presented in Table 3-40 and Table 3-41.

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Improving Adolescent Well-Care Visits

Table 3-40—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By 1/31/2021, 'Ohana Health Plan aims to increase the percentage of adolescent well-care visits assigned to Bay Clinic, Kalihi Palama Health Ctr, Dr. Sorbella Guillermo, Dr. Vincent Ramo, and Koolauloa Community Health and Wellness, from 44.66% to 49.66%."	44.66%	49.66%	40.00%	*Low Confidence*

Based on the SMART Aim run chart, the health plan did not meet the SMART Aim goal; therefore, HSAG assigned the PIP a score of *Low Confidence.*

'Ohana QI documented the following lessons learned for the *Improving Rates for Adolescent Well-Care Visits* PIP:

- Identify member education opportunities earlier. Most members did not know about the health plan's Healthy Rewards incentive program, and there were several delays in getting 2020 Healthy Rewards member materials approved and sent out. For 2021, the health plan has finalized the member materials early and are in the process of sending these materials to members by mid-year versus end of the year.
- Engage providers earlier to identify and bring members in since they are more familiar with their members.
- Consistently use the same source in generating the compliant and noncompliant member lists to ensure the most updated member listing.
- Request charts from providers in the target population to identify pseudo claims.

Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge

Table 3-41—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By 1/31/2021, increase the percentage of follow-up within seven days post hospitalization of discharges for members (ages 6 and older) discharged from Adventist Health Castle, Kahi Mohala Hospital, The Queens Medical Center, Hilo Medical Hospitalist, and Maui Memorial Hospital from 28.82% to 40.00%.	28.82%	40.00%	48.52%	*High Confidence*

Based on the intervention evaluation results and the SMART Aim run chart, the health plan exceeded the SMART Aim goal. It appears that the tested intervention could be linked to the improvement; therefore, HSAG assigned the PIP a score of *High Confidence*.

'Ohana QI documented the following lessons learned for the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP:

- Having the encounter information in a timely fashion is also a key part of the successful follow-up visits as it better supports qualified mental health practitioners (QMHPs.)
- Having QMHPs directly reach out to the members improves care coordination when members need additional support and further assessment, such as enrollment in the 'Ohana CCS program. The QMHPs are qualified to complete those assessments in addition to completing the follow-up visits for the members.

Strengths

- 'Ohana QI was successful in achieving desired outcomes for the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP. The health plan exceeded the SMART Aim goal, and it appears that the tested intervention could be linked to the improvement. Therefore, HSAG assigned the PIP a level of *High Confidence*.
- The health plan addressed HSAG's feedback during the PIP check-ins.

Areas for Improvement

- 'Ohana QI was not successful in achieving desired outcomes for the *Improving Adolescent Well-Care Visits* PIP. The tested intervention could not be linked to the demonstrated improvement.
- The health plan should ensure it is reaching an adequate number of members with an intervention to be able to reach the SMART Aim goal for the PIP. Accurate member contact information is crucial for success of an outreach intervention.

Recommendations

- When planning an intervention for testing, 'Ohana QI should think proactively about the potential barriers to testing the selected interventions. This may help ensure testing of interventions in a timely manner without delays.
- 'Ohana QI should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.
- 'Ohana QI should adopt/adapt plan-wide those interventions that were deemed successful.
- 'Ohana QI should continue its efforts to improve the performance on the PIP topics beyond the SMART Aim end date.

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

The following is a summary of the child CAHPS performance highlights for 'Ohana QI.

Findings

Table 3-42 presents the 2021 percentage of top-box responses for 'Ohana QI compared to the 2020 NCQA child Medicaid national averages and the corresponding 2019 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 2020 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-29]

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

Measure	2019 Scores	2021 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	65.2%	70.3%	★★
Rating of All Health Care	61.3%	68.2%	★
Rating of Personal Doctor	74.8%	73.3%	★
Rating of Specialist Seen Most Often	76.3%+	80.5%+	★★★★★
Composite Measures			
Getting Needed Care	79.1%	84.9%+	★★
Getting Care Quickly	79.6%	80.3%+	★
How Well Doctors Communicate	91.8%	95.8% ▲	★★★
Customer Service	80.2%	91.3%+ ▲	★★★★
Individual Item Measure			
Coordination of Care	88.6%+	88.0%+	★★★

Cells highlighted in yellow represent scores that are at or above the 2020 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2020 NCQA child Medicaid national averages.
▲ Indicates the 2021 score is statistically significantly higher than the 2019 score.
▼ Indicates the 2021 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

3-27 The adult population was last surveyed in 2020; therefore, the 2021 child CAHPS scores are compared to the corresponding 2019 scores.

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

3-29 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020*. Washington, DC: NCQA, September 2020.

Strengths

For ‘Ohana QI’s child Medicaid population, the following four measures met or exceeded the 2020 NCQA child Medicaid national averages:

- *Rating of Specialist Seen Most Often*
- *How Well Doctors Communicate*
- *Customer Service*
- *Coordination of Care*

In addition, the following two measures scored statistically significantly higher in 2021 than in 2019:

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

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

- *Rating of Specialist Seen Most Often*

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 the 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 3-43 provides a summary of the key drivers identified for ‘Ohana QI.

Table 3-43—’Ohana QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Child received care as soon as needed when care was needed right away		✓	
Ease of getting the care, tests, or treatment the child needed	✓	✓	✓
Child’s personal doctor discussed how the child is feeling, growing, or behaving		✓	✓

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Child's personal doctor seemed informed and up to date about care the child received from other doctors or health providers	✓		
The customer service area for the child's health plan gave the parent/caretaker the information or help needed	✓		N/A
Ease of filling out forms from the child's health plan		✓	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 to and timeliness of care 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.

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

- 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 the customer service area for the child's health plan did not always give them the information or help they needed.
- Respondents reported that forms from their child's health plan were often not easy to fill out.

Provider Survey

The following is a summary of the Provider Survey performance highlights for 'Ohana QI.

Findings

Table 3-44 presents the 2021 top-box scores compared to the QI Program aggregate and the corresponding 2018 top-box scores, where applicable, on the six domains of satisfaction for 'Ohana QI.[3-30]

[3-30] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2021 Hawaii Provider Survey full report.

Table 3-44—Provider Survey Results for 'Ohana QI

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	18.7%	18.7%	27.6%	↓	—
Timeliness of Claims Payments	31.3%	36.2%	47.0%	↓	—
Providing Quality Care					
Formulary	14.1%	7.0%	14.9%	↓	—
Prior Authorization Process	15.6%	8.3%	17.2%	↓	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	24.1%	15.8%	22.2%	↓	—
Service Coordinators					
Helpfulness of Service Coordinators	19.8%	28.2%	31.8%	—	▲
Specialists					
Adequate Network of Specialists	16.9%	9.7%	24.5%	↓	—
Availability of Mental Health Providers	10.2%	9.2%	13.6%	↓	—
Substance Abuse					
Access to Substance Abuse Treatment	15.9%	11.3%	19.2%	↓	—

↑ *Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2021 top-box score is statistically significantly higher than the 2018 top-box score.*
▼ *Indicates the 2021 top-box score is statistically significantly lower than the 2018 top-box score.*
— *Indicates the 2021 top-box score is not statistically significantly different than the 2018 top-box score.*

Strengths

For 'Ohana QI, the top-box score for the following measure was statistically significantly higher in 2021 than in 2018:

- *Helpfulness of Service Coordinators*

Areas for Improvement

For ‘Ohana QI, the top-box scores for the following eight measures were statistically significantly lower than the QI Program aggregate:

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

In addition, the top-box scores for the following six measures were lower in 2021 than in 2018, although no measure’s top-box score was statistically significantly lower:

- *Formulary*
- *Prior Authorization Process*
- *Adequate Access to Non-Formulary Drugs*
- *Adequate Network of Specialists*
- *Availability of Mental Health Providers*
- *Access to Substance Abuse Treatment*

Encounter Data Validation

The following is a summary of findings from an assessment of ‘Ohana QI’s processes for collecting, adjudicating, managing, and submitting encounter data to the State. HSAG conducted a targeted encounter data IS assessment to examine the extent to which ‘Ohana QI has appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. In collaboration with the MQD, HSAG developed questionnaires to gather information from ‘Ohana QI on general approaches to, and specific procedures for, data processing, personnel responsible for data, data acquisition capabilities, and data monitoring processes. The IS assessment component of the study provided self-reported qualitative information from ‘Ohana QI regarding its data processes. To conduct the administrative profile analysis, HSAG used various data sources including encounter data, member demographic/enrollment data, and provider data submitted by the MQD for the EDV study. HSAG examined encounters with dates of service from January 1, 2019, through December 31, 2019, with at least six months of run-out. The data presented below highlight results for ‘Ohana QI.

Findings

Targeted Encounter Data Information Systems Assessment

The IS assessment of 'Ohana QI's IS questionnaire responses demonstrated that 'Ohana QI has the capacity to collect, process, and transmit to the MQD claims and encounter data meeting established quality specifications. 'Ohana QI provided descriptions of the roles of internal personnel and departments as well as software systems and external vendors employed for activities such as claims and adjudication, and provider and member information verification; management of TPL information; and processing the encounter data reconciliation and rate files. 'Ohana QI also provided descriptions of its process as to how it monitors accuracy, completeness, and timeliness of encounter data submitted by its vendor(s) and/or provider(s).

The IS assessment also revealed that while 'Ohana QI's average rejection rate for claims rejected by the MQD's EDI translator was low, the average rejection rate for encounters that were rejected by the MQD's MMIS was high. Of note, these rejection rate patterns were similar to other health plans, where the high MMIS rejection rates were mostly due to provider-related issues (e.g., provider enrollment/activation). At the time of the questionnaire response submission, the MQD acknowledged that it is in the process of transitioning provider data flows from the previous process to a new provider system, HOKU. This new provider system is expected to alleviate the provider-related issues encountered during data processing, which have resulted in the submitted encounter data being rejected.

Administrative Profile

Figure 3-7 shows the percentage of accepted encounters with valid values for each listed data element. HSAG considered rates of valid values of 99 percent to be sufficiently high with no cause for concern. This criterion is not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-7—Key Encounter Data Elements, 'Ohana QI

Field	Professional	Inpatient	Long-Term Care	Hospital Outpatient	Pharmacy
Member ID	94.0% ✗	99.1%	99.7%	>99.9%	93.3% ✗
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	100.0%	100.0%	100.0%	100.0%	—
Detail First Date of Service	—	100.0%	100.0%	100.0%	—
Detail Last Date of Service	—	100.0%	100.0%	100.0%	—
Paid/Adjudication Date	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	92.3% ✗	NR ✗	NR ✗	NR ✗	99.9%
Rendering Provider ID	95.8% ✗	93.5% ✗	95.3% ✗	93.6% ✗	99.5%
Primary Diagnosis Code	99.5%	100.0%	100.0%	100.0%	—
Secondary Diagnosis Code(s)	>99.9%	100.0%	>99.9%	100.0%	—
CPT/HCPCS Code(s)	>99.9%	>99.9%	99.4%	>99.9%	—
Surgical Procedure Code(s)	—	100.0%	NR ✗	NR ✗	—
Revenue Code	—	>99.9%	98.7% ✗	>99.9%	—
NDC	—	—	—	—	99.4%
Number of applicable data elements evaulated for validity	9	13	12	13	6
Percentage of data elements meeting 99% or greater validity	66.7%	84.6%	75.0%	76.9%	83.3%

Note: NR indicates the rate is not reportable due to no denominator claims; Em-dash ("—") indicates the data element does not pertain to the claim type; ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code.

To assess 'Ohana QI's performance of encounter payment timeliness, HSAG compared the percentage of encounters paid within a typical lag of 180 days (approximately six months) to general standards based on HSAG's experience as an EQRO. HSAG considered a payment rate of 95 percent or greater as sufficient enough to minimally impact downstream analysis, while rates below 90 percent signified areas for improvement. HSAG considered rates between 90 and 95 percent as acceptable—that is, neither an area of particular concern nor especially high. These standards are not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-8 shows the percentage of encounters paid within 180 days (approximately six months) from the last date of service for 'Ohana QI.

Figure 3-8—Percentage of Encounters Paid Within 180 Days, 'Ohana QI

	'Ohana QI
Professional	84.6% ✗
Inpatient	69.5% ✗
Hospital Outpatient	89.2% ✗
Long-Term Care	91.6%
Pharmacy	97.8% ✓

✓ Greater than 95 percent paid within 180 days;
✗ Below 90 percent paid within 180 days.

Strengths

- Overall, more than 80 percent of the data elements analyzed for inpatient and pharmacy claim types met the validity criteria.
- Greater than 95 percent of all pharmacy care encounters were paid within 180 days from the last date of service.

Areas for Improvement

- Based on a review of 'Ohana QI's responses to the IS questionnaire, to monitor timeliness, 'Ohana QI ran a monthly provider submission report. 'Ohana should consider a more robust process to include metrics that calculate timeliness based on the date of service and payment date, as well as monitoring timeliness over time (e.g., week-to-week or month-to-month). Additionally, 'Ohana QI should consider adding more metrics to actively monitor encounter data completeness and accuracy before submitting files to the MQD. For example, the health plan could add current completeness metrics through highlighting abnormally high (e.g., due to duplicate records) or low (e.g., due to submission lags or incomplete data) volumes once trends have been established.
- Encounter lag for three encounter types was relatively low: professional, inpatient, and hospital outpatient. Less than 90 percent of these encounters were paid within a typical lag time of 180 days (approximately six months) as shown in Figure 3-8.
  - Impact: Timely payment and submission of encounters following their date of service is critical for conducting accurate analyses both for the MQD and its subcontractors, such as actuaries, its EQRO, and independent evaluators for Section 1115 and Section 1915 (c) demonstrations.[3-31] Lags in data submission could result in delayed analysis or incomplete or biased results.

[3-31] For example, the MQD currently has two active and approved Section 1115 waivers and one active and approved Section 1915 (c) waiver demonstration. CMS expects states to provide an interim evaluation report one year prior to the end of the Section 1115 waiver demonstration that consists of current findings in order to inform the decision on demonstration renewal.

Overall Assessment of Quality, Accessibility, 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 six EQR activities. While follow-up on compliance monitoring review findings indicated that 'Ohana QI continued to improve its operational foundation to support the quality, accessibility, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

Since 'Ohana QI performed well during the 2020 compliance review, only one corrective action item needed to be completed in 2021. Encompassing the *Subcontracts and Delegation* standard, 'Ohana QI took the necessary steps to ensure its subcontracts included a complete and accurate set of requirements and were executed to address identified deficiencies.

The EDV activities revealed that 'Ohana QI could benefit from implementing additional processes for monitoring the accuracy, completeness, and timeliness of encounter data. While more than 80 percent of the data elements analyzed for inpatient and pharmacy encounters met the validity criteria, professional, inpatient, and hospital outpatient encounters were paid inconsistently resulting in low claims payment rates at 180 days following the date of service. 'Ohana QI should consider a more robust process to include metrics that calculate timeliness based on the date of service and payment date, as well as monitoring timeliness over time.

While results from the compliance review activities demonstrated that 'Ohana QI continued to show that it had systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes, health plan performance indicators and member and provider satisfaction scores related to timeliness, accessibility, and quality of care were generally below the national Medicaid 50th percentile and QI program aggregate rates.

Overall, nearly two-thirds (64.5 percent) of 'Ohana QI's measures fell below the 50th percentile across all domains, with over half (51.6 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS MY 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 Children's Preventive Health, Women's Health, and Care for Chronic Conditions domains. Overall, five of the MQD Quality Strategy targets were met in HEDIS MY 2020.

'Ohana QI's CAHPS results illustrated mixed results regarding member satisfaction. Seven of the nine measures showed improvement in 2021 compared to the 2019 rates. Additionally, the *Rating of Specialist Seen Most Often* measure met or exceeded the 90th percentile, and the *Customer Service* measure met or exceeded the 75th percentile. Despite these improvements, five of the nine measures fell below the 2020 NCQA child Medicaid national averages. These results indicate the need for 'Ohana QI

to implement improvement strategies to ensure members have high-quality care and timely access to care.

The 2021 Provider Survey results illustrate the need for 'Ohana QI to investigate the reasons for significant provider dissatisfaction and implement quality improvement strategies to address the areas of concern. The top-box score for only one measure, *Helpfulness of Service Coordinators*, was statistically significantly higher in 2021 than in 2018. The top-box scores for all nine measures were below the QI Program aggregate rates, with top-box scores for eight of the nine measures being statistically significantly lower than the QI Program aggregate. These results indicate that providers are experiencing significant difficulties in providing high-quality and timely services and care to 'Ohana QI members.

Finally, 'Ohana QI completed and submitted Module 4 and Module 5 for the *Improving Rates for Adolescent Well-Care Visits* and *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIPs. These PIPs addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services. The validation findings suggest that 'Ohana QI was successful in achieving desired outcomes for the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP. The health plan exceeded the SMART Aim goal, and it appears that the tested intervention could be linked to the improvement. Therefore, HSAG assigned the PIP a level of *High Confidence*. For the *Improving Rates for Adolescent Well-Care Visits* PIP, the health plan did not meet the SMART Aim goal. HSAG assigned the PIP a level of *Low Confidence*. These results suggest that 'Ohana QI continues to have opportunities for improvement in executing the PIP process but shows an ability to appropriately apply key quality improvement principles.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

Compliance Monitoring Review

The 2021 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2020 review.

Findings

Table 3-45 presents the scores from HSAG's 2020 compliance review, the number of CAPs required, and the results of the 2021 follow-up reviews of UHC CP QI.

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

Standard #	Standard Name	2020 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2021 Final Follow-Up Review Score
I	Provider Selection	100%	0	NA	**100%**
II	Subcontracts and Delegation	100%	0	NA	**100%**
III	Credentialing	100%	0	NA	**100%**
IV	Quality Assessment and Performance Improvement	100%	0	NA	**100%**
V	Health Information Systems	100%	0	NA	**100%**
VI	Practice Guidelines	100%	0	NA	**100%**
VII	Program Integrity	91%	2	2	**100%**
VIII	Enrollment and Disenrollment	100%	0	0	**100%**
	Totals	**99%**	**2**	**2**	**100%**

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

Strengths

Since UHC CP QI performed well during the 2020 compliance review, only two corrective action items needed to be completed in 2021. To address the *Program Integrity* standard deficiencies, UHC CP QI updated its compliance plan and developed and implemented a policy to ensure that UHC CP QI and its subcontractors 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.

Areas for Improvement

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

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated UHC CP QI's IS capabilities for accurate HEDIS reporting. UHC CP QI was found to be *Fully Compliant* with all HEDIS 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 access, capture, translate, analyze, and report the selected measures. UHC CP QI elected to use five standard and eight nonstandard supplemental data sources for MY 2020 performance measure reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2020 performance measure reporting.

UHC CP QI passed MRRV in the prior year, and its MRR processes did not significantly change; therefore, a convenience sample was not required; however, UHC CP QI requested to undergo convenience sample validation. All convenience sample records successfully passed the validation process. MRRV was conducted for the following measures and corresponding measure groups as well as all medical record exclusions, and all records passed the validation without any critical issues:

- Group A: Biometrics (BMI, BP) & Maternity—*Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- Group C: Laboratory—*Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- Group D: Immunization & Other Screenings—*Childhood Immunization Status—Combination 10*
- Group F: Exclusions—All Medical Record Exclusions

Excluding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 6 to 17 years and 65 years and older stratifications, all QI measures that UHC CP QI was required to report were determined to be *Reportable*. A status of *NA (*i.e., *Small Denominator)* was assigned for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 6 to 17 years and 65 years and older stratifications. UHC CP QI followed the required specifications, but the denominator was too small to report a valid rate.

Because UHC CP QI was found to be fully compliant during the NCQA HEDIS Compliance Audit, the auditors did not have any recommendations for UHC CP QI.

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. The one rate in this domain that could be compared to national benchmarks ranked below the 50th percentile. All three rates for the non-HEDIS *Heart Failure Admission Rate* measure demonstrated a relative decline (i.e., improvement) of more than 19 percent. This represents an improvement in performance since lower rates for this measure indicates better performance. One measure in this domain had an MQD Quality Strategy target (i.e., *Heart Failure Admission Rate—Total),* and UHC CP QI met or exceeded the established target for HEDIS MY 2020.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Heart Failure Admission Rate*				
18–64 Years	68.80	55.08	-19.94%	NC
65 Years and Older	135.30	105.91	-21.72%	NC
Total	88.28	69.42	-21.36%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	10.37%	10.20%	-1.64%	★★
Expected Readmissions—Total	—	11.07%	—	NC
*Index Total Stays—O/E Ratio—Total**	0.93	0.92	-0.91%	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

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 *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures were new HEDIS measures; therefore, there were no prior year rates to compare to and no available benchmarks. Of note, two of the *Childhood Immunization Status* rates ranked at or above the 75th percentile, three rates ranked at or above the 50th percentile, and 14 rates fell below the 25th percentile. One measure in this domain had an MQD Quality Strategy target for HEDIS MY 2020 (i.e., *Childhood Immunization Status—Combination 3*), and UHC CP QI did not reach the established target.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Child and Adolescent Well-Care Visits[1]				
3–11 Years	—	40.93%	—	NC
12–17 Years	—	35.86%	—	NC
18–21 Years	—	14.77%	—	NC
Total	—	34.97%	—	NC

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Childhood Immunization Status				
Combination 2	—	64.72%	—	★
Combination 3	63.07%	62.53%	-0.86%	★
Combination 4	—	62.04%	—	★
Combination 5	—	51.34%	—	★
Combination 6	—	49.39%	—	★★★★
Combination 7	—	51.09%	—	★
Combination 8	—	49.15%	—	★★★★
Combination 9	—	41.12%	—	★★★
Combination 10	—	41.12%	—	★★★
DTaP	68.09%	67.40%	-1.01%	★
Hepatitis A	—	77.62%	—	★
Hepatitis B	81.16%	82.24%	1.33%	★
HiB	80.40%	80.78%	0.47%	★
Influenza	—	56.69%	—	★★★
IPV	80.40%	81.75%	1.68%	★
MMR	81.91%	80.54%	-1.67%	★
Pneumococcal Conjugate	68.09%	66.18%	-2.81%	★
Rotavirus	—	61.31%	—	★
VZV	80.90%	78.35%	-3.15%	★
Well-Child Visits in the First 30 Months of Life[1]				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	—	48.50%	—	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	67.14%	—	NC

[1] *Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

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 4 percent and ranked at or above the 75th percentile. Conversely, two measure rates reported a relative decline of more than 3 percent, one of which fell below the 25th percentile. Three measure rates[3-32] in this domain had an MQD Quality Strategy target for HEDIS MY 2020. UHC CP QI met or exceeded the established targets for two measure rates: *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*.

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Cervical Cancer Screening[1]				
Cervical Cancer Screening	53.53%	49.64%	-7.27%	★
Prenatal and Postpartum Care[1]				
Timeliness of Prenatal Care	91.48%	88.32%	-3.45%	★★
Postpartum Care	78.83%	82.24%	4.33%	★★★★

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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*

MY 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

UHC CP QI's Care for Chronic Conditions performance measure results are shown in Table 3-49. Out of four measure rates that could be compared to national benchmarks, two rates ranked at or above the 75th percentile, one rate ranked at or above the 50th percentile, and one rate ranked below the 50th percentile. MY 2020 represented the first year for reporting the non-HEDIS measure *Concurrent Use of Opioids and Benzodiazepines*; therefore, no prior year's rate is presented. Five measure rates[3-33] within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2020, and UHC CP QI met the target for three of these measure rates: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Blood Pressure Control (<140/90 mm Hg)*.

[3-32] 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.

[3-33] 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 3-49—UHC CP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Comprehensive Diabetes Care				
HbA1c Testing[2]	89.54%	87.10%	-2.73%	★★
*HbA1c Poor Control (>9.0%)**[2]	29.20%	31.63%	8.32%	★★★★
HbA1c Control (<8.0%)[2]	60.10%	57.91%	-3.64%	★★★★
Eye Exam (Retinal) Performed[2]	70.56%	63.02%	-10.69%	★★★
Blood Pressure Control (<140/90 mm Hg)[1]	—	64.23%	—	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	—	17.04%	—	NC
65 Years and Older	—	14.88%	—	NC
Total	—	16.14%	—	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, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, the prior year's rates are not displayed.
[2] Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Behavioral Health Performance Measure Results

UHC CP QI's Behavioral Health performance measure results are shown in Table 3-50. The *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up—Total* and *30-Day Follow-Up—Total* indicators demonstrated a relative increase of more than 20 percent. Two measure rates that could be compared to national benchmarks ranked at or above the 75th percentile, one rate ranked at or above the 50th percentile, and one measure rate ranked below the 50th percentile. MY 2020 represented the first year for reporting the non-HEDIS measures *Screening for Depression and Follow-Up Plan* and *Use of Pharmacotherapy for Opioid Use Disorder*; therefore, no prior years' rates are presented. Two measure rates[3-34] within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2020, and UHC CP QI met or exceeded both of the established targets.

[3-34] 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 3-50—UHC CP QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—6–17 Years	—	NA	—	NC
7-Day Follow-Up—18–64 Years	—	46.06%	—	★★★★
7-Day Follow-Up—65+ Years	—	NA	—	NC
7-Day Follow-Up—Total	32.43%	45.43%	40.09%	★★★★
30-Day Follow-Up—6–17 Years	—	NA	—	NC
30-Day Follow-Up—18–64 Years	—	57.88%	—	★★★
30-Day Follow-Up—65+ Years	—	NA	—	NC
30-Day Follow-Up—Total	47.45%	57.34%	20.84%	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	—	16.06%	—	NC
18–64 Years	—	7.61%	—	NC
65 Years and Older	—	26.18%	—	NC
18 Years and Older	—	14.11%	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	—	42.08%	—	NC
Buprenorphine	—	23.90%	—	NC
Oral Naltrexone	—	0.78%	—	NC
Long-Acting, Injectable Naltrexone	—	0.00%	—	NC
Methadone	—	19.48%	—	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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

Conclusions and Recommendations

Based on HSAG's analyses of UHC CP QI's 31 measure rates comparable to benchmarks, 12 measure rates (38.7 percent) ranked at or above the 50th percentile, with seven rates (22.6 percent) ranking at or above the 75th percentile, indicating positive performance in several areas, including follow-up visits for

members hospitalized for mental illness, care for members with diabetes, and postpartum care visits. Additionally, UHC CP QI met eight of the MQD Quality Strategy targets for HEDIS MY 2020.

Conversely, 19 of UHC CP QI's 31 measure rates comparable to benchmarks (61.3 percent) fell below the 50th percentile, with 15 rates (48.4 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:

- Children's Preventive Health
  - *Childhood Immunization Status—Combination 2, Combination 3, Combination 4, Combination 5, Combination 7*, *DTaP*, *Hepatitis A, Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate, Rotavirus,* and *VZV*
- Women's Health
  - *Cervical Cancer Screening*

Validation of Performance Improvement Projects

In CY 2021, UHC CP QI completed and submitted Module 4 and Module 5 for the *Improving Adolescent Well-Care Visits Rates Among UHCCP HI* Membership at Waianae Coast Comprehensive Health Center and *Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHCCP HI Members Ages 18–64* PIPs. These PIPs were initiated in CY 2019, and this is the final validation.

Findings

Module 4: Plan-Do-Study-Act

Module 4 is the intervention testing phase of the rapid-cycle PIP. In this module, the health plan conducts small tests of change using PDSA cycles.

Improving Adolescent Well-Care Visits Rates Among UHCCP HI Membership at Waianae Coast Comprehensive Health Center

For the PIP, the health plan tested one intervention, Adolescent Well-Care Call Outreach Campaign to Waianae Coast Comprehensive Health Center Auto-Assigned and Unestablished Members. The testing period was April 1, 2020, to January 31, 2021. During the check-ins, HSAG recommended that the health plan ensure it has a robust mechanism to track the success of the mailings as an outreach method by using an appropriate intervention effectiveness measure. HSAG also provided feedback on the data for the SMART Aim measure and recommended that the health plan consider additional PIP interventions such as improving data exchange processes with the schools for successful member outreach. In the final Module 4 submission, the health plan addressed HSAG's feedback on the SMART Aim measure data; however, the success with member outreach continued to be low partially because of

COVID-19 pandemic-related school-based clinics and provider office closures. The health plan indicated that it planned to adapt the outreach intervention to test at a later time.

Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHCCP HI Members Ages 18–64

The health plan tested two interventions for the PIP:

1. Provider Incentive Program: This intervention offered providers an additional $50 for completion of follow-up appointments within seven days of discharge for mental illness and was tested from April 1, 2020, to August 31, 2020. During the check-ins, HSAG provided feedback on the intervention effectiveness measure. The health plan addressed HSAG's feedback in the final Module 4 submission. The health plan indicated that the incentive was not effective in improving follow-up after discharge rates and therefore chose to abandon the intervention.
2. Offering a follow-up appointment using telehealth: The intervention was tested from September 1, 2020, to January 31, 2021, at two pilot facilities, Castle Hospital and Queens Medical Center. During the check-ins, HSAG provided feedback on the SMART Aim measure data. The health plan addressed HSAG's feedback in the final Module 4 submission. The health plan indicated that the intervention did not appear to be effective in improving the follow-up after discharge rates and that it planned to adapt the intervention.

Module 5: PIP Conclusions

HSAG organized and analyzed UHC CP QI's PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. The validation findings for UHC CP QI's PIPs are presented in Table 3-51 and Table 3-52.

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Improving Adolescent Well-Care Visits Rates Among UHCCP HI Membership at Waianae Coast Comprehensive Health Center

Table 3-51—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By 1/31/2021, increase the percentage of adolescent well-care visits completed among members assigned to Waianae Coast Comprehensive Health Center (WCCHC) as their PCP, from 26.94% to 29.94%	26.94%	29.94%	28.45%	*Low Confidence*

Based on the SMART Aim data, the results did not achieve the goal of 29.94 percent. The highest SMART Aim rate reported was 28.45 percent for the 12-month period of February 1, 2019, through January 31, 2020. The SMART Aim goal was not achieved; therefore, HSAG assigned the PIP a score of *Low Confidence*.

UHC CP QI documented the following lessons learned for the *Improving Adolescent Well-Care Visits Rates Among UHCCP HI Membership at Waianae Coast Comprehensive Health Center* PIP:

- It was challenging to plan for and transition to additional interventions for the PIP because the PIP and SMART Aim were developed around a specific provider's ability to see UHCCP HI members for adolescent well-care (AWC) visits.
- Within the intervention that was implemented, there was still an opportunity to improve the AWC rate through outreach to members assigned to but unestablished with WCCHC. Those members may have already established care with or preferred assignment to another provider. These members could be reassigned to their preferred PCP and removed from WCCHC's denominator while still offered support by UHC CP QI's customer services advocates (CSAs) for AWC visit coordination as needed.
- The lack of correct member contact information is a persistent barrier to engaging members/guardians who may be in the most need of healthcare navigation support.
- AWC, as a preventive care visit, was not a major area of focus for the provider partner during the COVID-19 pandemic.
- For members successfully contacted, AWC visit completion also did not seem to be a priority.
- Flexibility with planned intervention processes is critical to implementation.

Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHCCP HI Members Ages 18–64

Table 3-52—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By 1/31/2021, 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%	34.90%	40.29%	41.35%	*Low Confidence*

Based on the SMART Aim data, the goal (40.29 percent) was achieved for the 12-month period of May 1, 2019, through April 30, 2020, with a result of 41.35 percent. The SMART Aim goal was achieved at the beginning of intervention testing, and an intervention tested for the PIP could not be linked to the improvement. Following April 2020, the SMART Aim data points demonstrated a decline and were

below the baseline for the last seven months of the PIP. Therefore, HSAG assigned the PIP a score of *Low Confidence*.

UHC CP QI documented the following lessons learned for the *Improving 7–Day Follow-Up After Hospitalization for Mental Illness Among UHCCP HI Members Ages 18–64* PIP:

- Interventions that target providers are likely to be more effective if the health plan has knowledgeable staff members available to actively engage with the providers and support and educate them on the initiative, rather than dissemination of information solely through emails or fax.
- Members prefer to see their established mental health providers (MHPs) after discharge from an acute inpatient facility, even if available appointments are outside the seven-day *Follow-Up After Hospitalization for Mental Illness (FUH)* measure time frame. This is an opportunity for the health plan to educate both members and providers on the importance of *FUH* visits within seven days of discharge.
- Although telehealth may increase access to more MHPs and address some social determinants of health barriers (e.g., transportation and childcare issues), many members still lack the technology to access virtual visits, and member no-shows continue to be a persistent issue for the seven-day *FUH* measure. Additional efforts are needed to help members address technological and other ongoing barriers innovatively, especially during the COVID-19 pandemic when risk of virus transmission is still a concern.

Strengths

- The *Follow-Up After Hospitalization for Mental Illness* measure rate increased.

Areas for Improvement

- UHC CP QI was not successful in achieving desired outcomes for either PIP.
- The health plan should ensure it is reaching an adequate number of members with an intervention to be able to reach the SMART Aim goal for the PIP. Accurate member contact information is crucial for success of an outreach intervention.
- Interventions such as mailings are not member engaging and are discouraged to be used as a PIP intervention.

Recommendations

- When planning an intervention for testing, UHC CP QI should think proactively about the potential barriers to testing the selected interventions. This may help ensure testing of interventions in a timely manner without delays.
- UHC CP QI should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.
- UHC CP QI should adopt plan-wide the interventions that are deemed successful after continued testing.

- UHC CP QI should continue its efforts to improve the performance on the PIP topics beyond the SMART Aim end date.

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

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

Findings

Table 3-53 presents the 2021 percentage of top-box responses for UHC CP QI compared to the 2020 NCQA child Medicaid national averages and the corresponding 2019 scores.[3-35,3-36] Additionally, the overall member experience ratings (i.e., star ratings) resulting from UHC CP QI's top-box scores compared to NCQA's 2020 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-37]

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

Measure	2019 Scores	2021 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	65.9%	73.3% ▲	★★
Rating of All Health Care	66.0%	78.2% ▲	★★★★★
Rating of Personal Doctor	65.3%	80.3% ▲	★★★
Rating of Specialist Seen Most Often	66.7%+	83.7%+ ▲	★★★★★
Composite Measures			
Getting Needed Care	80.2%	80.7%+	★
Getting Care Quickly	83.0%	76.0%+	★
How Well Doctors Communicate	92.6%	94.6%	★★
Customer Service	84.1%+	87.7%+	★★
Individual Item Measure			
Coordination of Care	83.3%+	86.7%+	★★

3-35 The adult population was last surveyed in 2020; therefore, the 2021 child CAHPS scores are compared to the corresponding 2019 scores.

3-36 National Committee for Quality Assurance. *HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2020.

3-37 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

Measure	2019 Scores	2021 Scores	Star Ratings
Cells highlighted in yellow represent scores that are at or above the 2020 NCQA child Medicaid national averages. Cells highlighted in red represent scores that are below the 2020 NCQA child Medicaid national averages. ▲ Indicates the 2021 score is statistically significantly higher than the 2019 score. ▼ Indicates the 2021 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			

Strengths

For UHC CP QI's child Medicaid population, the following five measures met or exceeded the 2020 NCQA child Medicaid national averages:

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

In addition, the following four measures scored statistically significantly higher in 2021 than in 2019:

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

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

- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*

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 UHC CP QI.

Areas for Improvement

HSAG performed an analysis of the 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 3-54 provides a summary of the key drivers identified for UHC CP QI.

Table 3-54—UHC CP QI Key Drivers of Member Experience Analysis

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Child received care as soon as needed when care was needed right away	✓		
Ease of getting the care, tests, or treatment the child needed	✓		
Child's personal doctor explained things in an understandable way for the child			✓
Child's personal doctor spent enough time with the child		✓	
Child's personal doctor seemed informed and up to date about care the child received from other doctors or health providers	✓	✓	
Child received appointment with a specialist as soon as needed	✓		N/A
The customer service area for the child's health plan gave the parent/caretaker the information or help 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 to and timeliness of care for UHC CP 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 an area for improvement in the quality of care for UHC CP QI:

- Respondents reported that their child's personal doctor did not always explain things understandably to 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 the customer service area for their child's health plan did not always give them the information or help they needed.

Provider Survey

The following is a summary of the Provider Survey performance highlights for UHC CP QI.

Findings

Table 3-55 presents the 2021 top-box scores compared to the QI Program aggregate and the corresponding 2018 top-box scores, where applicable, on the six domains of satisfaction for UHC CP QI.[3-38]

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

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	24.6%	23.4%	27.6%	↓	—
Timeliness of Claims Payments	34.8%	41.8%	47.0%	↓	—
Providing Quality Care					
Formulary	17.3%	13.6%	14.9%	—	—
Prior Authorization Process	14.8%	13.8%	17.2%	↓	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	20.8%	17.7%	22.2%	↓	—
Service Coordinators					
Helpfulness of Service Coordinators	22.3%	27.6%	31.8%	—	▲
Specialists					
Adequate Network of Specialists	20.7%	21.0%	24.5%	—	—
Availability of Mental Health Providers	10.1%	13.2%	13.6%	—	—

[3-38] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2021 Hawaii Provider Survey full report.

	2018 Top-Box Score	2021 Top-Box Score	2021 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
Substance Abuse					
Access to Substance Abuse Treatment	18.1%	21.0%	19.2%	↑	—

↑ *Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program aggregate.*
↓ *Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program aggregate.*
▲ *Indicates the 2021 top-box score is statistically significantly higher than the 2018 top-box score.*
▼ *Indicates the 2021 top-box score is statistically significantly lower than the 2018 top-box score.*
— *Indicates the 2021 top-box score is not statistically significantly different than the 2018 top-box score.*

Strengths

For UHC CP QI, the top-box score for the following measure was statistically significantly higher than the QI Program aggregate:

- *Access to Substance Abuse Treatment*

In addition, the top-box score for the following measure was statistically significantly higher in 2021 than in 2018:

- *Helpfulness of Service Coordinators*

Areas for Improvement

For UHC CP QI, the top-box scores for the following four measures were statistically significantly lower than the QI Program aggregate:

- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Prior Authorization Process*
- *Adequate Access to Non-Formulary Drugs*

In addition, the top-box scores for the following four measures were lower in 2021 than in 2018, although no measure's top-box score was statistically significantly lower:

- *Compensation Satisfaction*
- *Formulary*
- *Prior Authorization Process*
- *Adequate Access to Non-Formulary Drugs*

Encounter Data Validation

The following is a summary of findings from an assessment of UHC CP QI's processes for collecting, adjudicating, managing, and submitting encounter data to the State. HSAG conducted a targeted encounter data IS assessment to examine the extent to which UHC CP QI has appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. In collaboration with the MQD, HSAG developed questionnaires to gather information from UHC CP QI on general approaches to, and specific procedures for, data processing, personnel responsible for data, data acquisition capabilities, and data monitoring processes. The IS assessment component of the study provided self-reported qualitative information from UHC CP QI regarding its data processes. To conduct the administrative profile analysis, HSAG used various data sources including encounter data, member demographic/enrollment data, and provider data submitted by the MQD for the EDV study. HSAG examined encounters with dates of service from January 1, 2019, through December 31, 2019, with at least six months of run-out. The data presented below highlight results for UHC CP QI.

Findings

Targeted Encounter Data Information Systems Assessment

The IS assessment of UHC CP QI's IS questionnaire responses demonstrated that UHC CP QI has the capacity to collect, process, and transmit to the MQD claims and encounter data meeting established quality specifications. UHC CP QI provided descriptions of the roles of internal personnel and departments as well as software systems and external vendors employed for activities such as claims and adjudication, and provider and member information verification; management of TPL information; and processing the encounter data reconciliation and rate files. UHC CP QI also provided descriptions of its process as to how it monitors accuracy, completeness, and timeliness of encounter data submitted by its vendor(s) and/or provider(s).

The IS assessment also revealed that while UHC CP QI's average rejection rate for claims rejected by the MQD's EDI translator was low, the average rejection rate for encounters that were rejected by the MQD's MMIS was high. Of note, these rejection rate patterns were similar to other MCOs, where the high MMIS rejection rates were mostly due to provider-related issues (e.g., provider enrollment/activation). At the time of the questionnaire response submission, the MQD acknowledged that it is in the process of transitioning provider data flows from the previous process to a new provider system, HOKU. This new provider system is expected to alleviate the provider-related issues encountered during data processing, which have resulted in the submitted encounter data being rejected.

Administrative Profile

Figure 3-9 shows the percentage of accepted encounters with valid values for each listed data element. HSAG considered rates of valid values of 99 percent to be sufficiently high with no cause for concern. This criterion is not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-9—Key Encounter Data Elements, UHC CP QI

Field	Professional	Inpatient	Long-Term Care	Hospital Outpatient	Pharmacy
Member ID	99.3%	99.5%	99.8%	>99.9%	99.9%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	>99.9%	100.0%	100.0%	100.0%	—
Detail First Date of Service	—	100.0%	>99.9%	>99.9%	—
Detail Last Date of Service	—	100.0%	>99.9%	>99.9%	—
Paid/Adjudication Date	>99.9%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	94.3% ✗	NR ✗	NR ✗	NR ✗	99.7%
Rendering Provider ID	94.0% ✗	92.9% ✗	94.5% ✗	93.3% ✗	98.1% ✗
Primary Diagnosis Code	99.5%	100.0%	100.0%	100.0%	—
Secondary Diagnosis Code(s)	>99.9%	100.0%	>99.9%	100.0%	—
CPT/HCPCS Code(s)	>99.9%	99.5%	96.8% ✗	>99.9%	—
Surgical Procedure Code(s)	—	100.0%	NR ✗	NR ✗	—
Revenue Code	—	>99.9%	98.1% ✗	100.0%	—
NDC	—	—	—	—	99.3%
Number of applicable data elements evaulated for validity	9	13	12	13	6
Percentage of data elements meeting 99% or greater validity	77.8%	84.6%	66.7%	76.9%	83.3%

Note: NR indicates the rate is not reportable due to no denominator claims; Em-dash ("—") indicates the data element does not pertain to the claim type; ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; NDC = National Drug Code.

To assess UHC CP QI's performance of encounter payment timeliness, HSAG compared the percentage of encounters paid within a typical lag of 180 days (approximately six months) to general standards based on HSAG's experience as an EQRO. HSAG considered a payment rate of 95 percent or greater as sufficient enough to minimally impact downstream analysis, while rates below 90 percent signified areas for improvement. HSAG considered rates between 90 and 95 percent as acceptable—that is, neither an area of particular concern nor especially high. These standards are not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plan accountable or for CAPs.

Figure 3-10 shows the percentage of encounters paid within 180 days (approximately six months) from the last date of service for UHC CP QI.

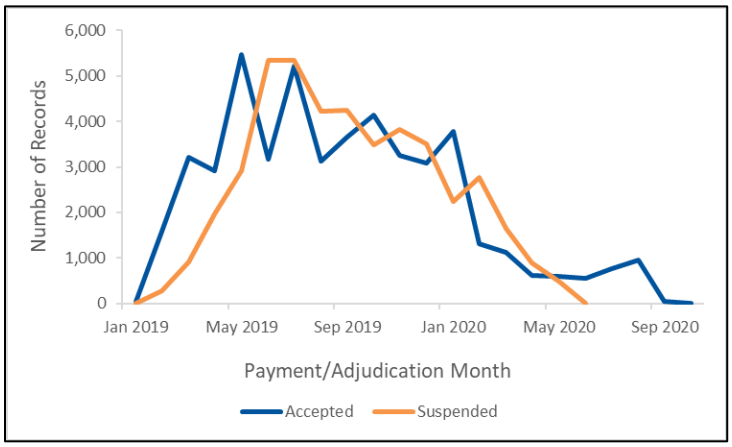
Figure 3-10—Percentage of Encounters Paid Within 180 Days, UHC CP QI

	UHC CP QI
Professional	87.4% ✗
Inpatient	82.6% ✗
Hospital Outpatient	95.3% ✓
Long-Term Care	94.1%
Pharmacy	97.2% ✓

✓ Greater than 95 percent paid within 180 days;
✗ Below 90 percent paid within 180 days.

Figure 3-11 presents the number of LTC encounter records over time for both accepted and suspended encounters. The number of pended encounters is approximately equal to the number of accepted encounters. This volume is substantially higher than other MCOs and encounter types. To the extent these suspended encounters represent unique services not captured in the accepted encounters system, analyses using accepted encounters may be incomplete.

Figure 3-11—Long-Term Care Encounter Records, UHC CP QI



Strengths

- Overall, more than 80 percent of the data elements analyzed for inpatient and pharmacy claim types met the validity criteria.
- Greater than 95 percent of all hospital outpatient and pharmacy encounters were paid within 180 days from the last date of service.

Areas for Improvement

- Based on a review of UHC CP QI's responses to the IS questionnaire, to monitor accuracy and completeness, UHC CP QI used the submission statistic report and the financial completeness report. UHC CP QI should consider a more robust process to include working with its providers to ensure accurate claims submissions and deliver provider education, as necessary. Additionally, UHC CP QI should consider adding more metrics to actively monitor encounter data completeness and accuracy before submitting files to the MQD. For example, to add current completeness metrics through highlighting abnormally high (e.g., due to duplicate records) or low (e.g., due to submission lags or incomplete data) volumes once trends have been established.
- Encounter lag for three encounter types was relatively low: professional, inpatient, and hospital outpatient. Less than 90 percent of these encounters were paid within a typical lag time of 180 days (approximately six months) as shown in Figure 3-10.
  - Impact: Timely payment and submission of encounters following their date of service is critical for conducting accurate analyses both for the MQD and its subcontractors such as actuaries, its EQRO, and independent evaluators for Section 1115 and section 1915 (c) demonstrations.[3-39] Lags in data submission could result in delayed analysis or incomplete or biased results.
- Large volume of LTC suspended encounters throughout 2019.
  - Impact: A large volume of suspended encounters indicates encounters not being accepted into the MMIS. This may show lower utilization/costs for LTC encounters in any analyses.

Overall Assessment of Quality, Accessibility, 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 six EQR activities. While follow-up on compliance monitoring review findings indicated that UHC CP QI continued to improve its operational foundation to support the quality, accessibility, and timeliness of care and service delivery, performance on outcome, member and provider satisfaction measures, and process measures showed room for improvement.

Since UHC CP QI performed well during the 2020 compliance review, only two corrective action items needed to be completed in 2021. Encompassing the *Program Integrity* standard, UHC CP QI took the

[3-39] For example, the MQD currently has two active and approved Section 1115 waivers and one active and approved Section 1915 (c) waiver demonstration. CMS expects states to provide an interim evaluation report one year prior to the end of the Section 1115 waiver demonstration that consists of current findings in order to inform the decision on demonstration renewal.

necessary steps to ensure its compliance plan was updated and that a new policy was developed and implemented to address identified deficiencies.

The EDV activities revealed that UHC CP QI could benefit from implementing additional processes for monitoring the accuracy, completeness, and timeliness of encounter data. While more than 80 percent of the data elements analyzed for inpatient and pharmacy encounters met the validity criteria, professional, inpatient, and hospital outpatient encounters were paid inconsistently, resulting in low claims payment rates at 180 days following the date of service. Additionally, a large volume of LTC encounters were suspended, which may show lower utilization/costs for LTC encounters in any analyses. UHC CP QI should consider a more robust encounter data monitoring process to include metrics for timeliness, completeness, and accuracy.

While results from the compliance review activities demonstrated that UHC CP QI continued to show that it had systems, policies, and staff in place to ensure that its structure and operations support core processes for providing care and services and promoting quality outcomes, health plan performance indicators and member and provider satisfaction scores related to timeliness and quality of, and access to care were generally below the national Medicaid 50th percentile and QI program aggregate rates.

Overall, nearly two-thirds (61.3 percent) of UHC CP QI's measure rates fell below the 50th percentile, with almost half (48.4 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS MY 2019, UHC CP QI's performance demonstrated the need to improve process and outcome measures across most domains. In particular, UCH CP QI should address performance in the Children's Preventive Health and Women's Health domains. Overall, eight of the MQD Quality Strategy targets were met in HEDIS MY 2020.

UHC CP QI's CAHPS results illustrated mixed results regarding member satisfaction. All four Global Rating measures scored statistically significantly higher in 2021 than in 2019 and scored at or above the 2020 NCQA child Medicaid national averages. Conversely, all four Composite Rating measures fell below the 2020 NCQA child Medicaid national averages. These results indicate the need for UHC CP QI to implement improvement strategies to ensure members have high-quality care and timely access to care.

The 2021 Provider Survey results illustrate the need for UHC CP QI to investigate the reasons for provider dissatisfaction and implement quality improvement strategies to address the areas of concern. The top-box score for only one measure, *Helpfulness of Service Coordinators*, was statistically significantly higher in 2021 than in 2018. Top-box scores for four of the measure rates, *Compensation Satisfaction*, *Timeliness of Claims Payments, Prior Authorization Process,* and *Adequate Access to Non-Formulary Drugs* were statistically significantly lower than the QI Program aggregate rates. Additionally, the top-box scores for four other measures were lower in 2021 than in 2018. These results indicate that providers are experiencing difficulties in providing high-quality and timely services and care to UHC CP QI members.

Finally, UHC CP QI completed and submitted Module 4 and Module 5 for the *Improving Adolescent Well-Care Visits Rates Among UHCCP HI Membership at Waianae Coast Comprehensive Health Center* and *Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHCCP HI*

Members Ages 18–64 PIPs. Both PIPs addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services. UHC CP QI was not successful in achieving desired outcomes for either PIP. The health plan did not meet the SMART Aim goal for *Improving Adolescent Well-Care Visits Rates Among UHCCP HI Membership at Waianae Coast Comprehensive Health Center*. For the *Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHCCP HI Members Ages 18–64*, even though the SMART Aim goal was achieved, the improvement could not be linked to the tested intervention. HSAG assigned both PIPs a level of *Low Confidence*. These results suggest that UHC CP QI continues to have opportunities for improvement in executing quality improvement processes.

'Ohana Community Care Services ('Ohana CCS) Results

Compliance Monitoring Review

The 2021 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2020 review.

Findings

Table 3-56 presents the scores from HSAG's 2020 compliance review, the number of CAPs required, and the results of the 2021 follow-up reviews of 'Ohana CCS.

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

Standard #	Standard Name	2020 Compliance Review Score	# of CAPs Required	# of CAPs Closed	2021 Final Follow-Up Review Score
I	Provider Selection	100%	0	NA	**100%**
II	Subcontracts and Delegation	95%	1	1	**100%**
III	Credentialing	100%	0	NA	**100%**
IV	Quality Assessment and Performance Improvement	100%	0	NA	**100%**
V	Health Information Systems	100%	0	NA	**100%**
VI	Practice Guidelines	100%	0	NA	**100%**
VII	Program Integrity	100%	0	NA	**100%**
VIII	Enrollment and Disenrollment	100%	0	0	**100%**
	Totals	**99%**	**1**	**1**	**100%**

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

Strengths

Since 'Ohana CCS performed well during the 2020 compliance review, only one corrective action item needed to be completed in 2021. To address the *Subcontracts and Delegation* standard deficiency, 'Ohana QI executed contract amendments with two of its subcontracts that included the correct timelines for medical record retention (10 years) in compliance with the State's health plan contract.

Areas for Improvement

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

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated 'Ohana CCS IS capabilities for accurate HEDIS reporting. 'Ohana CCS was found to be *Fully Compliant* with all HEDIS IS assessment standards. This demonstrated that 'Ohana CCS generally had the necessary systems, information management practices, processing environment, and control procedures in place to access, capture, translate, analyze, and report the selected measures. 'Ohana CCS elected to use four standard and two nonstandard supplemental data sources for MY 2020 reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2020 reporting. 'Ohana CCS used Enterprise Medical Management Application (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 all standard and nonstandard data sources were approved to use for HEDIS MY 2020 measure reporting.

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

'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 status of *NA* (i.e., *Small Denominator*). 'Ohana CCS followed the required specifications, but the denominator was too small to report a valid rate.

Because 'Ohana CCS was found to be fully compliant during the NCQA HEDIS Compliance Audit, the auditors did not have any recommendations for 'Ohana CCS.

Access and Risk-Adjusted Utilization Performance Measure Results

'Ohana CCS' Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-57. The *Ambulatory Care—Total (per 1,000 Member Months)—Outpatient Visits—Total* and *ED Visits—Total* and *Mental Health Utilization* measure rates are presented for information only, as lower or higher rates are not indicative of performance. Three measure rates in this domain had an MQD Quality Strategy target[3-40] for HEDIS MY 2020. 'Ohana CCS met or exceeded the established target for one of the measure rates.

[3-40] *Ambulatory Care—ED Visits—Total, Ambulatory Care—Outpatient Visits—Total,* and *Mental Health Utilization—Any Service.*

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	86.92	56.40	-35.11%	★★★
Outpatient Visits—Total	417.80	240.63	-42.41%	NC
Mental Health Utilization				
Inpatient	—	8.71%	—	NC
Intensive Outpatient or Partial Hospitalization	—	5.04%	—	NC
Outpatient	—	71.76%	—	NC
ED	—	1.16%	—	NC
Telehealth	—	56.41%	—	NC
Any Service	—	83.92%	—	NC

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 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*

Behavioral Health Performance Measure Results

'Ohana CCS' Behavioral Health performance measure results are shown in Table 3-58. Ten measure rates within this domain reported a relative improvement of more than 8 percent in HEDIS MY 2020, seven of which showed a relative improvement of more than 35 percent. Additionally, eight measure rates ranked at or above the 75th percentile, four of which met or exceeded the 90th percentile. Conversely, six measure rates ranked below the 50th percentile, two of which fell below the 25th percentile. Additionally, two measure rates in this domain had a relative decline of more than 5 percent in HEDIS MY 2020. Eleven measure rates[3-41] in this domain had an MQD Quality Strategy target for HEDIS MY 2020, and 'Ohana CCS met or exceeded eight of the established targets.

[3-41] *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment, Initiation and Engagement of AOD Abuse or Treatment—Initiation—Total—Total* and *Engagement—Total—Total,* and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia.*

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

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.95%	68.89%	-4.25%	★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.12%	47.02%	1.95%	★
Effective Continuation Phase Treatment	30.58%	33.33%	8.99%	★
Behavioral Health Assessment				
BHA Completion Within 14 Days of Enrollment (Within Standard)	40.00%	37.41%	-6.48%	NC
BHA Completion Within 15-30 Days of Enrollment (Not Within Standard)	16.86%	23.26%	37.96%	NC
BHA Completion within 31-60 Days of Enrollment (Not Within Standard)	7.57%	10.72%	41.61%	NC
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence[1]				
7 Day Follow-Up—13-17 Years	NA	NA	—	NC
7 Day Follow-Up—18+ Years	10.31%	17.46%	69.35%	★★★
7 Day Follow-Up—Total	10.31%	17.46%	69.35%	★★★
30 Day Follow-Up—13-17 Years	NA	NA	—	NC
30 Day Follow-Up—18+ Years	16.49%	26.98%	63.61%	★★★
30 Day Follow-Up—Total	16.49%	26.98%	63.61%	★★★
Follow-Up After Emergency Department Visit for Mental Illness[1]				
7-Day Follow-Up—6–17 Years	—	NA	—	NC
7-Day Follow-Up—18–64 Years	—	48.84%	—	★★★★
7-Day Follow-Up—65+ Years	—	NA	—	NC
7-Day Follow-Up—Total	44.50%	47.68%	7.15%	★★★
30-Day Follow-Up—6–17 Years	—	NA	—	NC
30-Day Follow-Up—18–64 Years	—	69.65%	—	★★★★
30-Day Follow-Up—65+ Years	—	NA	—	NC
30-Day Follow-Up—Total	65.50%	68.12%	4.00%	★★★★
Follow-Up After Hospitalization for Mental Illness[1]				
7-Day Follow-Up—6–17 Years	—	NA	—	NC
7-Day Follow-Up—18–64 Years	—	72.00%	—	★★★★★
7-Day Follow-Up—65+ Years	—	NA	—	NC
7-Day Follow-Up—Total	52.75%	71.69%	35.91%	★★★★★
30-Day Follow-Up—6–17 Years	—	NA	—	NC
30-Day Follow-Up—18–64 Years	—	88.47%	—	★★★★★
30-Day Follow-Up—65+ Years	—	NA	—	NC

Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	Relative Difference	MY 2020 Performance Level
30-Day Follow-Up—Total	72.75%	87.87%	20.78%	★★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment[1]				
Initiation—Total—13–17 Years	—	NA	—	NC
Initiation—Total—18+ Years	—	41.13%	—	★★
Initiation—Total—Total	43.69%	41.13%	-5.86%	★★
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18+ Years	—	13.06%	—	★★
Engagement—Total—Total	10.83%	13.06%	20.59%	★★

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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

MY 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*

Conclusions and Recommendations

Based on HSAG's analyses of the 20 'Ohana CCS measure rates with comparable benchmarks, 14 of these measure rates (70.0 percent) ranked at or above the 50th percentile. Four of the 14 measure rates (20.0 percent) ranked at or above the 75th percentile but below the 90th percentile, and four (20.0 percent) met or exceeded the 90th percentile, indicating positive performance related to follow-up after a discharge for mental illness. 'Ohana CCS met nine of the MQD Quality Strategy targets for HEDIS MY 2020.

Conversely, two measure rates (10.0 percent) fell below the 25th percentile, suggesting opportunities for improvement. HSAG recommends that 'Ohana CCS focus on improving performance related to the following measure with rates that fell below the 25th percentile for the CCS population:

- Behavioral Health
  - *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*

Validation of Performance Improvement Projects

For validation year 2021, ‘Ohana CCS submitted Module 4 and Module 5 for the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* and *Follow-Up After Emergency Department Visit for Mental Illness* PIPs. These PIPs were initiated in CY 2019, and this is the final validation.

Findings

Module 4 is the intervention testing phase of the rapid-cycle PIP. In this module, the health plan conducts small tests of change using PDSA cycles.

Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge

The health plan tested the following intervention during the PIP: Bi-directional communication between case management (CM) liaisons and member’s assigned case managers. During the check-ins, HSAG provided feedback on the intervention effectiveness measure and the possible errors in the SMART Aim measure. HSAG also recommended that the health plan resubmit modules 1 through 3 for the PIP due to a change in the narrowed focus prodder. The health plan addressed HSAG’s feedback in the final Module 4 submission. The intervention was tested from May 2020 through the SMART Aim end date. During the intervention testing period, based on the reported data, it appears that for 31 of the 52 total discharges, members had a compliant seven-day *FUH* visit. The intervention was deemed effective, and the health plan decided to adopt the intervention as a CAP for those Community Based Case Management organizations (CBCMs) who perform below the 75th percentile for the *Follow-Up After Hospitalization for Mental Illness (FUH)* measure.

Follow-Up After Emergency Department Visit for Mental Illness

For the PIP, the health plan tested one intervention: Utilize 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. During the check-ins, HSAG provided feedback on the intervention effectiveness measure and the changes made to the intervention as the PIP progressed. The health plan addressed HSAG’s feedback in the final Module 4 submission. The intervention was tested from August 2020 through the SMART Aim end date. During the intervention testing period, for 41 emergency department (ED) visits, the CM liaison sent the ED visit notifications to the members’ care manager within one business day post ED discharge. For 14 (34.15 percent) of these 41 visits, members had a compliant follow-up after ED visit for mental illness (*FUM*) visit. The health plan indicated challenges with its automated HHIE notification system. Consequently, the quality improvement project manager provided the ED notifications by manually accessing the HHIE Notify portal and facility census daily.

The intervention was deemed effective; however, the health plan noted that manual notification of ED visits was not feasible. The health plan will adapt the intervention once the health plan is able to automate the HHIE ED census notification.

Module 5: PIP Conclusions

HSAG organized and analyzed 'Ohana CCS' PIP data to draw conclusions about the health plan's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. The validation findings for 'Ohana CCS' PIPs are presented in Table 3-59 and Table 3-60.

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge

Table 3-59—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By 1/31/2021, increase the percentage of the follow-up post hospitalization within seven days for those discharged for mental illness among the members, ages 18 and older, who are assigned to the selected Community Based Case Management Agencies (Aloha House and Hope Inc.) from 51.72% to 63.79%	51.72%	63.79%	73.84%	*High Confidence*

Based on the intervention evaluation results and the SMART Aim run chart, the health plan exceeded the SMART Aim goal. It appears that the tested intervention could be linked to the improvement; therefore, HSAG assigned the PIP a score of *High Confidence*.

'Ohana CCS documented the following lessons learned for the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP:

- By monitoring and working closely with CM leads, there are opportunities to educate CM leads on the specifications of the measures.
- Interacting with the CBCMs frequently increases engagement in the post-discharge tasks that need to be completed in a timely fashion.

Follow-Up After Emergency Department Visit for Mental Illness

Table 3-60—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By 1/31/2021, increase the percentage of follow-up within 7 days post ED visits for mental illness	44.68%	53.00%	53.84%	*Confidence*

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
or intentional self-harm for the members (age 18 and older) who are assigned to ‘Ohana Health Plan and Institute for Human Services (IHS) from 44.68% to 53.00%				

Based on the SMART Aim run chart, the health plan exceeded the SMART Aim goal in the last two months of the PIP. It appears that the tested intervention, if adapted, has the potential to result in improvement; therefore, HSAG assigned the PIP a score of *Confidence*.

‘Ohana CCS documented the following lessons learned for the *Follow-Up After Emergency Department Visit for Mental Illness* PIP:

- The PIP team enhanced the ED notification report to include all ED encounters as opposed to the visits for mental illness. This information helped the health plan locate members for successful outreach.
- Communication with CMs is more efficient when reaching out to the CM leads of the CBCMs. Frequent communication between CM and liaisons strengthens relationships and helps obtain information from the CBCMs about new ED encounters that the ‘Ohana CCS PIP team had not yet obtained and vice versa.

Strengths

- ‘Ohana CCS was successful in achieving desired outcomes for both PIPs. The health plan met the SMART Aim goal and the tested interventions that could be linked to the demonstrated improvement.
- The health plan addressed HSAG’s feedback during the check-ins.

Areas for Improvement

- ‘Ohana CCS should think proactively about the potential barriers to testing the selected interventions. This may help ensure testing of interventions in a timely manner without delays.

Recommendations

- ‘Ohana CCS should apply lessons learned and knowledge gained to future PIPs and quality improvement activities.
- ‘Ohana CCS should adopt/adapt plan-wide those interventions that were deemed successful.
- ‘Ohana CCS should continue its efforts to improve the performance on the PIP topics beyond the SMART Aim end date.

Overall Assessment of Quality, Accessibility, 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. Since 'Ohana CCS performed well during the 2020 compliance review, only one corrective action item needed to be completed in 2021. Encompassing the *Subcontracts and Delegation* standard, 'Ohana CCS took the necessary steps to ensure its subcontracts included a complete and accurate set of requirements and were executed to address identified deficiencies.

Overall, nearly three-quarters (70.0 percent) of 'Ohana CCS' measure rates ranked at or above the 50th percentile, with six measure rates (30.0 percent) falling below the 50th percentile. 'Ohana CCS should address performance in the Behavioral Health domain. Overall, nine of the MQD Quality Strategy targets were met in HEDIS MY 2020.

Finally, 'Ohana CCS submitted the following PIP topics for validation: *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* and *Follow-Up After Emergency Department Visit for Mental Illness.* These PIPs addressed CMS' requirements related to quality outcomes—specifically, the timeliness of, and access to, care and services. The validation findings suggest that 'Ohana CCS was successful in achieving desired outcomes for both PIPs. The health plan met the SMART Aim goal and the tested interventions that could be linked to the demonstrated improvement. HSAG assigned a level of *High Confidence* to the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP and a level of *Confidence* to the *Follow-Up After Emergency Department Visit for Mental Illness* PIP.

'Ohana CCS' cumulative results in the three EQR activities indicate that 'Ohana CCS has systems, policies, and staff in place to ensure that its structure and operations support core processes for ensuring its members have access to timely and quality healthcare.

4. Comparative Analysis of Health Plan Performance

Introduction

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

Compliance Monitoring Review

Table 4-1 provides information that can be used to compare all five Hawaii Medicaid managed care health plans' performance on implementing CAPs required to resolve deficiencies for each of the six compliance standard areas reviewed the prior year.

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

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Total # CAPs per Standard
I. Provider Selection	1/1	NA	1/1	NA	NA	NA	**2/2**
II. Subcontracts and Delegation	1/1	NA	6/6	1/1	NA	1/1	**9/9**
III. Credentialing	NA	1/1	1/1	NA	NA	NA	**2/2**
IV. Quality Assessment and Performance Improvement	NA	NA	NA	NA	NA	N/A	**NA**
V. Health Information Systems	NA	NA	NA	NA	NA	NA	**NA**
VI. Practice Guidelines	NA	NA	NA	NA	NA	NA	**NA**
VII. Program Integrity	NA	1/1	2/2	NA	2/2	NA	**5/5**
VIII. Enrollment and Disenrollment	NA	NA	NA	NA	NA	NA	**NA**
Total # CAPs and Resolved CAPs by Health Plan:	**2/2**	**2/2**	**10/10**	**1/1**	**2/2**	**1/1**	**18/18**

Numerator = # of CAPs "closed" and found compliant during follow-up review.
Denominator = Total # CAPs required for the standard following prior year (2020) compliance review.
NA = Not Applicable. Reevaluation was not necessary as the health plan achieved 100 percent for the standard.

Across all six health plans, performance was strongest in the areas of *Quality Assessment and Performance Improvement, Health Information Systems, Practice Guidelines,* and *Enrollment and Disenrollment* during the previous year's review, with no CAPs requiring follow-up this year.

The *Subcontracts and Delegation* standard had the most individual elements requiring CAPs (nine) followed by the *Program Integrity* standard with five elements requiring CAPs. KFHP QI had most individual elements requiring correction. 'Ohana QI and 'Ohana CCS had the fewest standard areas and individual elements requiring CAPs (one).

All six health plans successfully resolved all CAP areas during the 2021 reevaluation period.

Validation of Performance Measures—HEDIS Compliance Audits

NCQA HEDIS Compliance Audits

Table 4-2 compares each QI health plan's compliance with each HEDIS IS standard reviewed during the MY 2020 NCQA HEDIS Compliance Audit.

Table 4-2—Validation of Performance Measures Comparison: NCQA HEDIS Compliance Audit Information Systems Review Results

QI Health Plan	IS 1.0 Medical Services Data	IS 2.0 Enrollment Data	IS 3.0 Provider Data	IS 4.0 Medical Record Review Processes	IS 5.0 Supplemental Data	IS 6.0 Data Preproduction Processing	IS 7.0 Data Integration and Reporting
AlohaCare QI	*Fully Compliant*	*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*	*Fully Compliant*
KFHP QI	*Fully Compliant*	*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*	*Fully Compliant*
UHC CP QI	*Fully Compliant*	*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' MY 2020 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2019 percentiles, where applicable. 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 the 25th 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 MY 2020 Access and Risk-Adjusted Utilization Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Heart Failure Admission Rate*					
18–64 Years	42.95 —	21.52 —	37.73 —	80.25 —	55.08 —
65 Years and Older	147.04 —	63.03 —	107.76 —	177.64 —	105.91 —
Total	53.26 —	23.84 —	42.72 —	97.31 —	69.42 —
Plan All-Cause Readmissions					
*Index Total Stays—Observed Readmissions—Total**	8.46% ★★★★	7.99% ★★★★	8.15% ★★★★	10.54% ★★	10.20% ★★
Expected Readmissions—Total	10.14% —	9.57% —	9.98% —	11.62% —	11.07% —
*Index Total Stays—O/E Ratio—Total**	0.83 —	0.83 —	0.82 —	0.91 —	0.92 —

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
** 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 Access and Risk-Adjusted Utilization performance measure domain, four of five QI health plans met the MQD's established target for the one measure with an MQD Quality Strategy target for HEDIS MY 2020 (i.e., *Heart Failure Admission Rate—Total*). For the *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* rate, three of five QI health plans (i.e., AlohaCare QI, HMSA QI, and KFHP QI) ranked at or above the 75th percentile. Conversely, 'Ohana QI and UHC CP QI ranked below the 50th percentile.

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 MY 2020 Children's Preventive Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Child and Adolescent Well-Care Visits[1]					
3–11 Years	45.75% —	55.78% —	43.43% —	41.46% —	40.93% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
12–17 Years	41.53% —	52.69% —	34.36% —	38.11% —	35.86% —
18–21 Years	16.67% —	27.22% —	11.28% —	16.53% —	14.77% —
Total	39.80% —	50.26% —	35.54% —	36.69% —	34.97% —
Childhood Immunization Status					
Combination 2	56.69% ★	71.29% ★★	82.50% ★★★★★	63.78% ★	64.72% ★
Combination 3	53.53% ★	68.61% ★★	80.42% ★★★★★	61.86% ★	62.53% ★
Combination 4	51.82% ★	66.91% ★★	80.42% ★★★★★	60.90% ★	62.04% ★
Combination 5	45.99% ★	56.20% ★	74.31% ★★★★★	54.49% ★	51.34% ★
Combination 6	40.15% ★★	49.15% ★★★★	68.89% ★★★★★	48.72% ★★★	49.39% ★★★★
Combination 7	44.53% ★	55.23% ★	74.31% ★★★★★	53.53% ★	51.09% ★
Combination 8	39.17% ★★	48.91% ★★★★	68.89% ★★★★★	48.40% ★★★	49.15% ★★★★
Combination 9	34.06% ★★	41.36% ★★★	63.75% ★★★★★	43.91% ★★★	41.12% ★★★
Combination 10	33.33% ★★	41.12% ★★★	63.75% ★★★★★	43.59% ★★★	41.12% ★★★
DTaP	62.53% ★	76.89% ★★	84.58% ★★★★	66.03% ★	67.40% ★
Hepatitis A	74.45% ★	86.37% ★★★	90.42% ★★★★	76.92% ★	77.62% ★
Hepatitis B	74.21% ★	82.24% ★	91.25% ★★★	76.92% ★	82.24% ★
HiB	76.16% ★	89.29% ★★★	88.19% ★★★	77.56% ★	80.78% ★
Influenza	52.31% ★★★	58.64% ★★★★	74.72% ★★★★★	56.41% ★★★	56.69% ★★★
IPV	76.89% ★	87.10% ★★	91.39% ★★★	78.21% ★	81.75% ★
MMR	78.10% ★	89.54% ★★★	91.25% ★★★	78.53% ★	80.54% ★
Pneumococcal Conjugate	59.85% ★	76.40% ★★	82.64% ★★★★	64.74% ★	66.18% ★
Rotavirus	58.64% ★	70.32% ★★	81.94% ★★★★★	63.14% ★	61.31% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
VZV	78.10% ★	87.35% ★★	90.56% ★★★	78.85% ★	78.35% ★
Well-Child Visits in the First 30 Months of Life[1]					
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	60.38% —	67.17% —	68.91% —	58.58% —	48.50% —
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.26% —	78.88% —	84.62% —	66.38% —	67.14% —

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, NCQA recommends a break in trending between MY 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 Children's Preventive Health performance measure domain, the *Childhood Immunization Status* measure rates were the only rates in this domain that could be compared to national benchmarks. KFHP QI performed best among the health plans, with all 19 measure rates ranking at or above the 50th percentile, three of which met or exceeded the 75th percentile and 11 of which met or exceeded the 90th percentile. AlohaCare QI, 'Ohana QI, and UHC CP QI demonstrated the lowest performance among the health plans, with 14 of 19 measure rates ranking below the 25th percentile.

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 MY 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 MY 2020 Women's Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Cervical Cancer Screening					
Cervical Cancer Screening	50.61% ★	64.17% ★★★	74.90% ★★★★★	47.20% ★	49.64% ★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	81.27% ★	83.45% ★	93.60% ★★★★	86.42% ★★	88.32% ★★
Postpartum Care	76.64% ★★★	72.02% ★★	83.60% ★★★★	72.83% ★★	82.24% ★★★★

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

Within the Women's Health performance measure domain, KFHP QI performed best among the health plans, with all three measure rates meeting or exceeding the 75th percentile, one of which met or exceeded the 90th percentile. AlohaCare QI, 'Ohana QI, and UHC CP QI demonstrated the worst performance for the *Cervical Cancer Screening* measure, ranking below the 25th percentile. Of note, KFHP QI and HMSA QI reached the MQD's established target for the *Cervical Cancer Screening* measure.

For the *Prenatal and Postpartum Care* measure rates, all QI health plans met the MQD's established targets except AlohaCare QI's *Timeliness of Prenatal Care* rate. Of note, KFHP QI ranked at or above the 75th percentile for both measure rates, and UHC CP QI ranked at or above the 75th percentile for the *Postpartum Care* rate.

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 MY 2020 Care for Chronic Conditions Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Comprehensive Diabetes Care					
HbA1c Testing	82.73% ★	82.73% ★	86.88% ★★	82.73% ★	87.10% ★★
*HbA1c Poor Control (>9.0%)**	39.66% ★★	34.55% ★★★	41.05% ★★	39.17% ★★	31.63% ★★★★
HbA1c Control (<8.0%)	49.64% ★★	53.77% ★★★	49.04% ★★	53.28% ★★★	57.91% ★★★★
Eye Exam (Retinal) Performed	58.15% ★★	63.26% ★★★	58.42% ★★	61.31% ★★★	63.02% ★★★
Blood Pressure Control (<140/90 mm Hg)[1]	54.74% —	57.42% —	57.14% —	59.61% —	64.23% —
Concurrent Use of Opioids and Benzodiazepines					
18–64 Years	9.77% —	14.50% —	8.44% —	21.63% —	17.04% —
65 Years and Older	12.20% —	9.30% —	2.94% —	17.62% —	14.88% —
Total	10.00% —	14.24% —	7.63% —	20.76% —	16.14% —

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, NCQA recommends a break in trending between MY 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure.*

* *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, UHC CP QI performed best among the health plans, with three of the four measure rates that could be compared to benchmarks ranking at or above the 50th percentile, two of which ranked at or above the 75th percentile. Additionally, HMSA QI ranked at or above the 50th percentile for three of four measure rates. AlohaCare QI and KFHP QI demonstrated the worst performance among the health plans, having all four measure rates fall below the 50th percentile.

The five *Comprehensive Diabetes Care* measure indicators within the Care for Chronic Conditions domain were associated with an MQD Quality Strategy target in HEDIS MY 2020. UHC CP QI reached three of the established targets, 'HMSA QI met two established targets, and 'Ohana QI met one established target. AlohaCare QI and KFHP QI did not meet any of the established MQD targets.

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 MY 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—6–17 Years	NA	47.34% ★★★	NA	NA	NA
7-Day Follow-Up—18–64 Years	30.57% ★★	40.20% ★★★★	38.54% ★★★★	51.27% ★★★★★	46.06% ★★★★
7-Day Follow-Up—65+ Years	NA	NA	NA	NA	NA
7-Day Follow-Up—Total	30.65% ★★	41.80% ★★★	43.70% ★★★★	50.81% ★★★★	45.43% ★★★★
30-Day Follow-Up—6–17 Years	NA	67.46% ★★	NA	NA	NA
30-Day Follow-Up—18–64 Years	44.54% ★★	58.80% ★★★	55.21% ★★★	73.42% ★★★★★	57.88% ★★★
30-Day Follow-Up—65+ Years	NA	NA	NA	NA	NA
30-Day Follow-Up—Total	44.44% ★	60.86% ★★★	58.82% ★★	70.81% ★★★★	57.34% ★★
Screening for Depression and Follow-Up Plan					
12–17 Years	20.27% —	47.25% —	2.07% —	14.22% —	16.06% —
18–64 Years	6.65% —	23.96% —	10.89% —	8.20% —	7.61% —
65 Years and Older	12.34% —	25.38% —	13.79% —	25.03% —	26.18% —
18 Years and Older	7.27% —	24.04% —	11.14% —	12.08% —	14.11% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Use of Pharmacotherapy for Opioid Use Disorder					
Total	48.09% —	50.68% —	44.21% —	46.33% —	42.08% —
Buprenorphine	28.95% —	32.74% —	33.68% —	16.61% —	23.90% —
Oral Naltrexone	1.20% —	1.63% —	1.05% —	1.60% —	0.78% —
Long-Acting, Injectable Naltrexone	0.00% —	0.20% —	0.00% —	0.00% —	0.00% —
Methadone	20.33% —	18.00% —	13.68% —	30.35% —	19.48% —

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

Within the Behavioral Health domain, *Follow-Up After Hospitalization for Mental Illness* was the only measure with MQD-established Quality Strategy targets. Four of five QI health plans (i.e., HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI) met the established targets for the *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates. Four of five QI health plans (i.e., AlohaCare QI, KFHP QI, 'Ohana QI, and UHC CP QI) did not have enough members in the eligible population for the *7-Day Follow-Up—6–17 Years* and *30-Day Follow-Up—6–17 Years* measure indicators to report a rate, and none of the QI health plans had enough members in the eligible population for the *7-Day Follow-Up—65+ Years* and *30-Day Follow-Up—65+ Years* measure indicators and were assigned a status of *NA*. AlohaCare QI did not reach any of the established targets for the measure rates, and the four measure rates that were reported fell below the 50th percentile, with one of these rates ranking below the 25th percentile.

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
Access and Risk-Adjusted Utilization					
Heart Failure Admission Rate—Total	Met	Met	Met	Not Met	Met
Children's Preventive Health					

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Childhood Immunization Status—Combination 3	Not Met	Not Met	Met	Not Met	Not Met
Women's Health					
Cervical Cancer Screening	Not Met	Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Not Met	Met	Met	Met	Met
Prenatal and Postpartum Care—Postpartum Care	Met	Met	Met	Met	Met
Care for Chronic Conditions					
Comprehensive Diabetes Care—HbA1c Testing	Not Met	Not Met	Not Met	Not Met	Not Met
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	Not Met	Met	Not Met	Not Met	Met
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	Not Met	Met	Not Met	Met	Met
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Not Met	Not Met	Not Met	Not Met	Not Met
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Not Met	Not Met	Not Met	Not Met	Met
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	Not Met	Met	Met	Met	Met
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	Not Met	Met	Met	Met	Met
Total MQD Targets Met	**2**	**8**	**7**	**5**	**8**
Percent MQD Targets Met	**16.67%**	**66.67%**	**58.33%**	**41.67%**	**66.67%**

All five health plans had reportable rates for the 12 applicable measure rates with MQD Quality Strategy targets. HMSA QI and UHC CP QI met or exceeded eight of 12 (66.67 percent) MQD Quality Strategy targets, followed by KFHP QI, which met or exceeded the MQD Quality Strategy targets for seven of 12 (58.33 percent) measures. 'Ohana QI met five of 12 (41.67 percent) MQD Quality Strategy targets, and AlohaCare QI met two of 12 (16.67 percent) MQD Quality Strategy targets. These results, in combination with overall HEDIS measure rates, suggest considerable room for improvement for AlohaCare QI and 'Ohana QI in meeting the goals outlined in the MQD Quality Strategy.

Based on health plan performance relative to the MQD Quality Strategy targets, only one QI health plan met the MQD Quality Strategy target for the *Childhood Immunization Status—Combination 3* measure indicator, suggesting that children were not receiving these immunizations, which are a critical aspect of preventable, timely, and comprehensive care for children. Immunization declines may have coincided

with the COVID-19 public health emergency and the temporary suspension of nonurgent services. HSAG recommends the QI health plans conduct a root cause analysis or focus study to determine why its child members are not receiving all recommended vaccines. QI health plans could consider if there are disparities within its population that contribute to lower performance or if a particular vaccine or vaccines within the combination are missed more often than others, contributing to lower rates.

Only two of five QI health plans met the established MQD Quality Strategy target for the *Cervical Cancer Screening* measure, suggesting a need for better commitment to preventive screenings in the primary care setting and early detection of cervical pre-cancers which could lead to a significant reduction in death rates for this cancer. Early detection not only reduces the risk of dying from cervical cancer but can lead to a greater range of treatment options and lower healthcare costs.

Several QI health plans did not meet the established MQD Quality Strategy target for the *Comprehensive Diabetes Care* measure indicators, indicating that members are not receiving services needed for proper diabetes management. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. HSAG recommends the QI health plans conduct a root cause analysis or focus study to determine why its members are not receiving timely care to properly manage their diabetes. QI health plans could implement community initiatives to better educate its members about the importance of proper diabetes management to improve population health.

Validation of Performance Improvement Projects

Table 4-9 summarizes HSAG's key validation findings for the two PIPs conducted by the QI health plans. The key validation findings include whether each PIP achieved its SMART Aim goal and the overall confidence level HSAG assigned to each PIP.

Table 4-9—PIP Validation Findings for the QI Health Plans

Health Plan	Adolescent Well-Care Visits		Follow-Up After Hospitalization for Mental Illness	
	SMART Aim Goal Achieved	Confidence Level	SMART Aim Goal Achieved	Confidence Level
AlohaCare QI	*Yes*	*Low Confidence*	*Yes*	*High Confidence*
HMSA QI	*Yes*	*Low Confidence*	*Yes*	*Confidence*
KFHP QI	*No*	*Low Confidence*	*No*	*Low Confidence*
'Ohana QI	*No*	*Low Confidence*	*Yes*	*High Confidence*
UHC CP QI	*No*	*Low Confidence*	*Yes*	*Low Confidence*

Table 4-10 summarizes HSAG's key validation findings for the two PIPs conducted by 'Ohana CCS.

Table 4-10—PIP Validation Findings for 'Ohana CCS

	Follow-Up After Hospitalization for Mental Illness		Follow-Up After Emergency Department Visit for Mental Illness	
Health Plan	SMART Aim Goal Achieved	Confidence Level	SMART Aim Goal Achieved	Confidence Level
'Ohana CCS	*Yes*	*High Confidence*	*Yes*	*High Confidence*

CY 2021 was the final validation year for these PIPs. To target the goals and objectives included in the MQD Quality Strategy, for the next set of PIPs, the MQD should review the performance of the health plans on the HEDIS and other nationally accredited performance measures that are aligned to the State's Quality Strategy and goals. The determination of the new PIP topics should be data driven and aligned to the State's Quality Strategy. In addition to mandating the PIP topics, the MQD could also require the health plans to implement specific interventions for the PIPs based on evidence-based strategies and peer-review studies. The health plans should also be required to document how they have implemented the learnings from the previous PIPs to improve the outcomes in the new PIPs. Effective member engagement strategies and provider and organizational leadership engagement are some of the key components for a successful PIP. Seeking member input regarding barriers toward access to care may also be an important tool toward determining interventions and improving outcomes.

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

Statewide Comparisons—QI Health Plans

Table 4-11 presents the 2021 percentage of top-box scores for each QI health plan and the QI Program aggregate.[4-1] Additionally, the QI health plans' results compared to the overall QI Program aggregate are displayed below.

Table 4-11—Comparison of 2021 QUEST Integration Child CAHPS Results

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	QI Program Aggregate
Global Ratings						
Rating of Health Plan	75.3%	76.1%	78.4%	70.3%	73.3%	75.1%
Rating of All Health Care	73.9%	72.0%	82.1% ↑	68.2%	78.2%	74.9%
Rating of Personal Doctor	82.2%	82.9%	86.4% ↑	73.3% ↓	80.3%	81.8%
Rating of Specialist Seen Most Of	78.6%+	68.6%+	75.9%+	80.5%+	83.7%+	76.4%

[4-1] 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.

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	QI Program Aggregate
Composite Measures						
Getting Needed Care	80.1%+	84.2%	86.6%	84.9%+	80.7%+	83.6%
Getting Care Quickly	79.2%+	82.9%	88.8% ↑	80.3%+	76.0%+	81.9%
How Well Doctors Communicate	94.1%	95.2%	97.0%	95.8%	94.6%	95.4%
Customer Service	83.9%+	87.2%+	92.4%+	91.3%+	87.7%+	88.3%
Individual Item Measure						
Coordination of Care	87.2%+	82.3%+	95.8%+	88.0%+	86.7%+	88.4%

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

Comparison of the QI Program aggregate and QI health plans' scores to the 2020 NCQA child Medicaid national averages revealed the following summary results:

- 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 All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Coordination of Care.*
- HMSA QI scored at or above the national average on three measures: *Rating of Health Plan, Rating of All Health Care,* and *Rating of Personal Doctor.*
- KFHP QI scored at or above the national average on eight measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, How Well Doctors Communicate, Customer Service,* and *Coordination of Care.*
- 'Ohana QI scored at or above the national average on four measures: *Rating of Specialist Seen Most Often, How Well Doctors Communicate, Customer Service,* and *Coordination of Care.*
- UHC CP QI scored at or above the national average on five measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *Coordination of Care.*

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

- AlohaCare QI and HMSA QI did not score statistically significantly higher or lower than the QI Program aggregate on any of the measures.

- KFHP QI scored statistically significantly higher than the QI Program aggregate on three measures: *Rating of All Health Care*, *Rating of Personal Doctor*, and *Getting Care Quickly*. Conversely, KFHP QI did not score statistically significantly lower than the QI Program aggregate on any of the measures.
- 'Ohana QI did not score statistically significantly higher than the QI Program aggregate on any of the measures. Conversely, 'Ohana QI scored statistically significantly lower than the QI Program aggregate on one measure: *Rating of Personal Doctor*.
- 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 4-12 presents the 2021 top-box scores for the Hawaii CHIP population.

Table 4-12—Comparison of 2021 CHIP CAHPS Results

Global Ratings	
Rating of Health Plan	78.2% ▲
Rating of All Health Care	74.5% ▲
Rating of Personal Doctor	77.7%
Rating of Specialist Seen Most Often	75.3%+
Composite Measures	
Getting Needed Care	87.2% ▲
Getting Care Quickly	82.8%
How Well Doctors Communicate	97.2%
Customer Service	82.9%+
Individual Item Measure	
Coordination of Care	90.4%

Cells highlighted in yellow represent scores that are at or above the 2020 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2020 NCQA child Medicaid national averages.
▲ Indicates the 2021 score is statistically significantly higher than the 2020 score.
▼ Indicates the 2021 score is statistically significantly lower than the 2020 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

An evaluation of the CHIP population's 2021 scores to the 2020 NCQA child Medicaid national averages revealed the following summary results:

- The CHIP population scored at or above the national averages on six measures: *Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, How Well Doctors Communicate,* and *Coordination of Care.*

- The CHIP population scored below the national averages on three measures: *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service*.

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

- The CHIP population's 2021 scores were statistically significantly higher than the 2020 scores on three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Getting Needed 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 2020 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 4-13.[4-2]

Table 4-13—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 4-14 shows the QI Program aggregates and each participating QI health plan's member experience ratings and top-box scores for each of the four global ratings.

Table 4-14—NCQA Comparisons: Global Ratings

	Rating of Health Plan	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*
QI Program	★★★ **75.1%**	★★★ **74.9%**	★★★★ **81.8%**	★★★★ **76.4%**

[4-2] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020*. Washington, DC: NCQA, September 2020.

	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
AlohaCare QI	★★★ 75.3%	★★★ 73.9%	★★★★ 82.2%	★★★★★+ 78.6%
HMSA QI	★★★★ 76.1%	★★ 72.0%	★★★★ 82.9%	★+ 68.6%
KFHP QI	★★★★★ 78.4%	★★★★★ 82.1%	★★★★★ 86.4%	★★★★+ 75.9%
‘Ohana QI	★★ 70.3%	★ 68.2%	★ 73.3%	★★★★★+ 80.5%
UHC CP QI	★★ 73.3%	★★★★★ 78.2%	★★★ 80.3%	★★★★★+ 83.7%
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.				

Table 4-15 shows the QI Program aggregates 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 4-15—NCQA Comparisons: Composite and Individual Item Measures

	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care
QI Program	★ **83.6%**	★ **81.9%**	★★ **95.4%**	★★ **88.3%**	★★★ **88.4%**
AlohaCare QI	★+ 80.1%	★+ 79.2%	★ 94.1%	★+ 83.9%	★★★+ 87.2%
HMSA QI	★★ 84.2%	★ 82.9%	★★ 95.2%	★★+ 87.2%	★+ 82.3%
KFHP QI	★★★ 86.6%	★★ 88.8%	★★★★ 97.0%	★★★★+ 92.4%	★★★★★+ 95.8%
‘Ohana QI	★★+ 84.9%	★+ 80.3%	★★★ 95.8%	★★★★+ 91.3%	★★★+ 88.0%
UHC CP QI	★+ 80.7%	★+ 76.0%	★★ 94.6%	★★+ 87.7%	★★+ 86.7%
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating 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*.

- HMSA QI's and KFHP QI's member experience ratings met or exceeded the 75th percentile for *Rating of Health Plan*.
- No QI health plans' member experience ratings met or exceeded the 75th percentile for *Getting Needed Care*.
- KFHP QI's member experience rating met or exceeded the 75th percentile for *How Well Doctors Communicate*.

NCQA Comparisons—CHIP

Table 4-16 presents the overall member experience ratings and 2021 top-box scores for the Hawaii CHIP population on each of the four global ratings, four composite measures, and one individual item measure.[4-3]

Table 4-16—NCQA Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	78.2%	★★★★★
Rating of All Health Care	74.5%	★★★
Rating of Personal Doctor	77.7%	★★
Rating of Specialist Seen Most Often	75.3%+	★★★★
Composite Measures		
Getting Needed Care	87.2%	★★★
Getting Care Quickly	82.8%	★
How Well Doctors Communicate	97.2%	★★★★
Customer Service	82.9%+	★
Individual Item Measure		
Coordination of Care	90.4%	★★★★

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

[4-3] 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.

Comparison of the CHIP population's scores to NCQA's 2020 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The CHIP population scored at or above the 90th percentile on one measure, *Rating of Health Plan*.
- The CHIP population scored below the 25th percentile on two measures: *Getting Care Quickly* and *Customer Service*.

Provider Survey

Plan Comparisons

Table 4-17 presents a summary of the statistically significant differences in performance that existed between the QI health plans' 2021 top-box scores (i.e., percent satisfied).[4-4]

Table 4-17—Plan Comparisons

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

[4-4] For more detailed results on the plan comparisons analysis, please see the 2021 Hawaii Provider Survey full report.

	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Substance Abuse					
Access to Substance Abuse Treatment	↑	↑	↑	↓	↑

↑ Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program aggregate.
↓ Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program aggregate.
— Indicates the QI health plan's top-box score is not statistically significantly different than the QI Program aggregate.
Results based on fewer than 11 respondents were suppressed and noted as "NA".

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

- For *Compensation Satisfaction*, AlohaCare QI's and HMSA QI's 2021 top-box scores (34.4 percent and 32.4 percent, respectively) were statistically significantly higher than the QI Program aggregate, while 'Ohana QI's and UHC CP QI's 2021 top-box scores (18.7 percent and 23.4 percent, respectively) were statistically significantly lower than the QI Program aggregate.
- For *Timeliness of Claims Payments*, AlohaCare QI's and HMSA QI's 2021 top-box scores (52.8 percent and 55.7 percent, respectively) were statistically significantly higher than the QI Program aggregate, while 'Ohana QI's and UHC CP QI's 2021 top-box scores (36.2 percent and 41.8 percent, respectively) were statistically significantly lower than the QI Program aggregate.
- For *Formulary*, HMSA QI's and KFHP QI's 2021 top-box scores (18.1 percent and 51.6 percent, respectively) were statistically significantly higher than the QI Program aggregate, while 'Ohana QI's 2021 top-box score (7.0 percent) was statistically significantly lower than the QI Program aggregate.
- For *Prior Authorization Process*, AlohaCare QI's and HMSA QI's 2021 top-box scores (21.7 percent and 23.0 percent, respectively) were statistically significantly higher than the QI Program aggregate, while 'Ohana QI's and UHC CP QI's 2021 top-box scores (8.3 percent and 13.8 percent, respectively) were statistically significantly lower than the QI Program aggregate.
- For *Adequate Access to Non-Formulary Drugs*, AlohaCare QI's and KFHP QI's 2021 top-box scores (28.1 percent and 87.5 percent, respectively) were statistically significantly higher than the QI Program aggregate, while 'Ohana QI's and UHC CP QI's 2021 top-box scores (15.8 percent and 17.7 percent, respectively) were statistically significantly lower than the QI Program aggregate.
- For *Helpfulness of Service Coordinators*, KFHP QI's 2021 top-box score (77.4 percent) was statistically significantly higher than the QI Program aggregate, while none of the other QI health plans' 2021 top-box scores were statistically significantly higher or lower than the QI Program aggregate.
- For *Adequate Network of Specialists*, HMSA QI's and KFHP QI's 2021 top-box scores (37.0 percent and 78.8 percent, respectively) were statistically significantly higher than the QI Program aggregate, while 'Ohana QI's 2021 top-box score (9.7 percent percent) was statistically significantly lower than the QI Program aggregate.

- For *Availability of Mental Health Providers*, KFHP QI's 2021 top-box score (36.7 percent) was statistically significantly higher than the QI Program aggregate, while 'Ohana QI's 2021 top-box score (9.2 percent) was statistically significantly lower than the QI Program aggregate.
- For *Access to Substance Abuse Treatment*, AlohaCare QI's, HMSA QI's, KFHP QI's, and UHC CP QI's 2021 top-box scores (23.0 percent, 20.8 percent, 56.7 percent, and 21.0 percent, respectively) were statistically significantly higher than the QI Program aggregate, while 'Ohana QI's 2021 top-box score (11.3 percent) was statistically significantly lower than the QI Program aggregate.

Trend Analysis

To evaluate trends in performance, HSAG compared the 2021 top-box scores to the corresponding 2018 top-box scores, where applicable. Table 4-18 presents a summary of the measures that had statistically significant differences between the 2021 and 2018 top-box scores.[4-5] Please note, there were no statistically significant differences for the QI Program, HMSA QI, or KFHP QI.

Table 4-18—Trend Analysis

	AlohaCare QI	'Ohana QI	UHC CP QI
Non-Formulary			
Adequate Access to Non-Formulary Drugs	▲	—	—
Service Coordinators			
Helpfulness of Service Coordinators	—	▲	▲

▲ *Indicates the 2021 top-box score is statistically significantly higher than the 2018 top-box score.*
▼ *Indicates the 2021 top-box score is statistically significantly lower than the 2018 top-box score.*
— *Indicates the 2021 top-box score is not statistically significantly different than the 2018 top-box score.*

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

- For *Adequate Access to Non-Formulary Drugs*, AlohaCare QI's 2021 top-box score (28.1 percent) was statistically significantly higher than the 2018 top-box score (22.6 percent).
- For *Helpfulness of Service Coordinators*, 'Ohana QI's and UHC CP QI's 2021 top-box scores (28.2 percent and 27.6 percent, respectively) were statistically significantly higher than the 2018 top-box scores (19.8 percent and 22.3 percent, respectively).

[4-5] For more detailed results on the trend analysis, please see the 2021 Hawaii Provider Survey full report.

Encounter Data Validation

Plan Comparisons

EDV Project Highlights

The MQD contracted with HSAG to perform an EDV study as part of CMS' Protocol 5. The EDV study focused on three activities:

1. Targeted EDV IS assessment
2. Gap analysis and best practice recommendations for data quality assessment
3. Administrative profile

This review assessed the quality, completeness, and timeliness of encounter data submitted to the MQD.

Data Validity Findings

HSAG assessed the validity of values found across all commonly used data elements and data elements of particular interest to the MQD. HSAG considered rates of valid values of 99 percent to be sufficiently high and no reason for concern. This criterion is not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plans accountable or for CAPs. Figure 4-1 shows that across all data elements assessed for professional encounters, 'Ohana QI met the valid value criterion for only two-thirds of data elements; all health plans met the criterion for 84.6 percent of data elements for inpatient encounters; UHC CP QI met the criterion for only two-thirds of LTC encounters while KFHP QI met the criterion for over 90 percent of data elements and AlohaCare QI and HMSA QI met the criterion for over 80 percent of data elements. Among hospital outpatient encounters, AlohaCare QI and HMSA QI met the criterion for 84.6 percent of data elements; all health plans met the criterion for over 80 percent of pharmacy encounters, with HMSA QI and KFHP QI meeting the criterion for all data elements examined for validity.

Figure 4-1—Percentage of Data Elements Meeting 99 Percent Valid Value Criterion

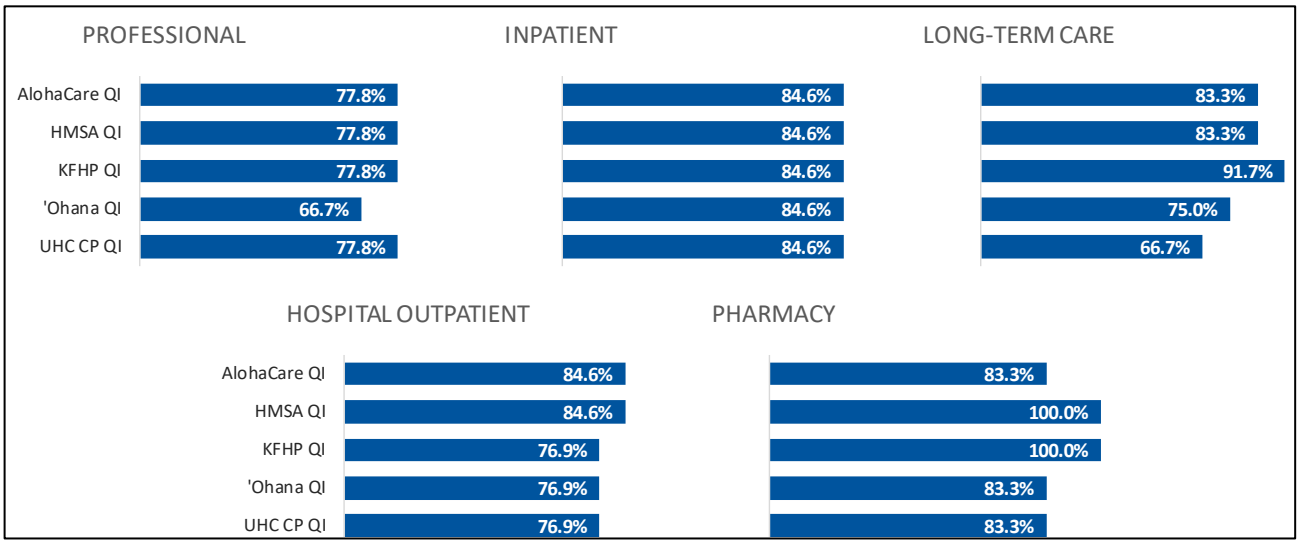


Figure 4-2 shows the data elements assessed for professional encounters across all health plans. AlohaCare QI, HMSA QI, KFHP QI, and UHC CP QI each met the 99 percent validity criterion for seven of nine (77.8 percent) data elements evaluated, and 'Ohana QI met six of nine (66.7 percent). None of the health plans met the 99 percent validity criterion for rendering provider ID (NPI). This was primarily driven by low referential integrity between the provider ID in the encounters and the supplied provider reference file.

Figure 4-2—Key Encounter Data Elements, Professional Encounters

Field	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Member ID	99.9%	99.8%	99.7%	94.0% ✗	99.3%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	100.0%	>99.9%	100.0%	100.0%	>99.9%
Paid/Adjudication Date	100.0%	>99.9%	100.0%	100.0%	>99.9%
Billing Provider ID	93.6% ✗	93.8% ✗	99.1%	92.3% ✗	94.3% ✗
Rendering Provider ID	98.9% ✗	98.5% ✗	94.4% ✗	95.8% ✗	94.0% ✗
Primary Diagnosis Code	99.3%	99.3%	97.7% ✗	99.5%	99.5%
Secondary Diagnosis Code(s)	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%
CPT/HCPCS Code(s)	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%
Number of data elements meeting 99% or greater validity	7	7	7	6	7
Percentage of data elements meeting 99% or greater validity	77.8%	77.8%	77.8%	66.7%	77.8%

Note: ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System.

Figure 4-3 shows the data elements assessed for inpatient encounters across all health plans. All health plans met the 99 percent validity criterion for 11 of 13 (84.6 percent) data elements, with all health plans not meeting the criterion for billing provider ID (NPI) and rendering provider ID (NPI).

Figure 4-3—Key Encounter Data Elements, Inpatient Encounters

Field	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Member ID	99.5%	99.5%	99.8%	99.1%	99.5%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Detail First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Detail Last Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Paid/Adjudication Date	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	NR ✗	NR ✗	NR ✗	NR ✗	NR ✗
Rendering Provider ID	92.3% ✗	90.8% ✗	90.8% ✗	93.5% ✗	92.9% ✗
Primary Diagnosis Code	100.0%	100.0%	100.0%	100.0%	100.0%
Secondary Diagnosis Code(s)	100.0%	100.0%	100.0%	100.0%	100.0%
CPT/HCPCS Code(s)	100.0%	100.0%	100.0%	>99.9%	99.5%
Surgical Procedure Code(s)	100.0%	100.0%	100.0%	100.0%	100.0%
Revenue Code	100.0%	100.0%	100.0%	>99.9%	>99.9%
Number of data elements meeting 99% or greater validity	11	11	11	11	11
Percentage of data elements meeting 99% or greater validity	84.6%	84.6%	84.6%	84.6%	84.6%

Note: NR indicates the rate is not reportable due to no denominator claims; ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System.

Figure 4-4 shows the data elements assessed for LTC encounters across all health plans. KFHP QI met the 99 percent validity criterion for 11 of 12 (91.7 percent) assessed data elements, AlohaCare QI and HMSA QI met 10 of 12 (83.3 percent) data elements, 'Ohana QI met nine of 12 (75.0 percent) data elements, and UHC CP QI met eight of 12 (66.7 percent). No health plans met the 99 percent validity criterion for billing provider ID (NPI), and only KFHP QI met the 99 percent validity criterion for rendering provider ID (NPI).

Figure 4-4—Key Encounter Data Elements, Long-Term Care Encounters

Field	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Member ID	>99.9%	99.5%	100.0%	99.7%	99.8%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Detail First Date of Service	>99.9%	100.0%	100.0%	100.0%	>99.9%
Detail Last Date of Service	>99.9%	100.0%	100.0%	100.0%	>99.9%
Paid/Adjudication Date	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	NR ✗	NR ✗	NR ✗	NR ✗	NR ✗
Rendering Provider ID	94.6% ✗	90.3% ✗	99.5%	95.3% ✗	94.5% ✗
Primary Diagnosis Code	100.0%	100.0%	100.0%	100.0%	100.0%
Secondary Diagnosis Code(s)	100.0%	>99.9%	100.0%	>99.9%	>99.9%
CPT/HCPCS Code(s)	100.0%	100.0%	100.0%	99.4%	96.8% ✗
Revenue Code	99.9%	100.0%	100.0%	98.7% ✗	98.1% ✗
Number of data elements meeting 99% or greater validity	10	10	11	9	8
Percentage of data elements meeting 99% or greater validity	83.3%	83.3%	91.7%	75.0%	66.7%

Note: NR indicates the rate is not reportable due to no denominator claims; ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System.

Figure 4-5 shows the data elements assessed for hospital outpatient encounters across all health plans. Both AlohaCare QI and HMSA QI met the 99 percent validity criterion for 11 of 13 (84.6 percent) data elements, and KFHP QI, 'Ohana QI, and UHC CP QI met 10 of 13 (76.9 percent) data elements. None of the health plans met the 99 percent validity criterion for billing provider ID and rendering provider ID. KFHP QI, 'Ohana QI, and UHC CP QI did not meet the 99 percent validity criterion for surgical procedure codes.

Figure 4-5—Key Encounter Data Elements, Hospital Outpatient Encounters

Field	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Member ID	>99.9%	99.9%	>99.9%	>99.9%	>99.9%
Header First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Header Last Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Detail First Date of Service	>99.9%	100.0%	100.0%	100.0%	>99.9%
Detail Last Date of Service	>99.9%	100.0%	100.0%	100.0%	>99.9%
Paid/Adjudication Date	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	NR ✗	NR ✗	NR ✗	NR ✗	NR ✗
Rendering Provider ID	94.0% ✗	92.9% ✗	87.9% ✗	93.6% ✗	93.3% ✗
Primary Diagnosis Code	100.0%	100.0%	100.0%	100.0%	100.0%
Secondary Diagnosis Code(s)	100.0%	100.0%	100.0%	100.0%	100.0%
CPT/HCPCS Code(s)	100.0%	100.0%	100.0%	>99.9%	>99.9%
Surgical Procedure Code(s)	100.0%	100.0%	NR ✗	NR ✗	NR ✗
Revenue Code	>99.9%	100.0%	100.0%	>99.9%	100.0%
Number of data elements meeting 99% or greater validity	11	11	10	10	10
Percentage of data elements meeting 99% or greater validity	84.6%	84.6%	76.9%	76.9%	76.9%

Note: NR indicates the rate is not reportable due to no denominator claims; ✗ Did not meet 99 percent valid value criterion; CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System.

Figure 4-6 shows the data elements assessed for pharmacy encounters across all health plans. HMSA QI and KFHP QI met the 99 percent validity criterion for all data elements, and AlohaCare QI, 'Ohana QI, and UHC CP QI met the 99 percent validity criterion for five of six (83.3 percent) data elements.

Figure 4-6—Key Encounter Data Elements, Pharmacy Encounters

Field	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Member ID	>99.9%	>99.9%	>99.9%	93.3% ✗	99.9%
First Date of Service	100.0%	100.0%	100.0%	100.0%	100.0%
Paid/Adjudication Date	100.0%	100.0%	100.0%	100.0%	100.0%
Billing Provider ID	99.7%	99.7%	100.0%	99.9%	99.7%
Prescribing Provider ID	98.8% ✗	99.1%	99.2%	99.5%	98.1% ✗
NDC	99.7%	99.9%	99.2%	99.4%	99.3%
Number of data elements meeting 99% or greater validity	5	6	6	5	5
Percentage of data elements meeting 99% or greater validity	83.3%	100.0%	100.0%	83.3%	83.3%

Note: ✗ Did not meet 99 percent valid value criterion; NDC = National Drug Code.

Data Timeliness Findings

To assess health plan performance of encounter payment timeliness, HSAG compared the percentage of encounters paid within a typical lag of 180 days (approximately six months) to general standards based

on HSAG's experience as an EQRO. HSAG considered a payment rate of 95 percent or greater as sufficient enough to minimally impact downstream analysis, while rates below 90 percent signified areas for improvement. HSAG considered rates between 90 and 95 percent as acceptable—that is, neither an area of particular concern nor especially high. These standards are not specified in the MQD's contracts with the health plans and should not be used in any way to hold the health plans accountable or for CAPs.

Figure 4-7 shows the percentage of encounters paid within 180 days (approximately six months) from the last date of service. HMSA QI had greater than 95 percent of encounters paid within 180 days for four of five encounter types, KFHP QI had greater than 95 percent of encounters paid within 180 days for three of five encounter types, UHC CP QI had 95 percent of encounters paid within 180 days for two of five encounter types, and AlohaCare QI and 'Ohana QI had 95 percent of encounters paid within 180 days for one of five encounter types. All health plans, except KFHP QI, met the 95 percent criterion for pharmacy encounters. All health plans, except HMSA QI, fell below the 90 percent mark for professional claims.

Figure 4-7—Percentage of Encounters Paid Within 180 days, by Health Plan

Service Category	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Professional	89.5% ✗	92.9%	32.6% ✗	84.6% ✗	87.4% ✗
Inpatient	89.8% ✗	98.6% ✓	96.5% ✓	69.5% ✗	82.6% ✗
Hospital Outpatient	87.9% ✗	99.4% ✓	98.4% ✓	89.2% ✗	95.3% ✓
Long-Term Care	94.8%	99.2% ✓	98.6% ✓	91.6%	94.1%
Pharmacy	99.4% ✓	98.9% ✓	58.8% ✗	97.8% ✓	97.2% ✓

✓ Greater than 95 percent paid within 180 days; ✗ Below 90 percent paid within 180 days.

Assessing and ensuring the quality, timeliness, and accessibility of healthcare services among HI Medicaid members is in part reliant on the MQD and its vendors having quality and timely data. For instance, calculation of performance measures is dependent on encounter and eligibility data. The EDV study, therefore, plays a pivotal role in ensuring the State's and health plans' data and information systems are of sufficient quality to support further assessment of the MQD's Quality Strategy targets. Without complete and accurate encounter data in the MQD's data warehouse, it could be difficult to monitor and improve quality of care and access to care.

Findings from the analysis of encounter data quality (e.g. data validity) show one area of particular concern related to the referential integrity of provider NPIs in the encounter data and provider reference file. This may limit the ability to accurately calculate performance measures that rely on the identification of certain providers and/or provider types. However, HSAG determined that the provider Medicaid IDs were sufficient and could be used instead of NPIs for analysis until NPIs are complete in the encounter and provider reference data. Additionally, based on reviewing the MQD's encounter data companion guide documentation, the provider Medicaid ID information was the required field to be submitted. MQD may consider updating the companion guide to collect the NPI field.

Findings from the analysis of encounter data timeliness show several plans with low rates of encounter completeness after a typical lag time of 180 days (six months). This lag time in payment could affect the encounters available to the MQD and its vendors/contractors for analysis. HSAG recommends that the MQD ensure KFHP QI submits encounters in a timely manner to the data warehouse. Additionally, to ensure health plans' accountability for submitting encounters in a timely manner, the MQD may consider requiring all health plans to develop an enhanced timeliness monitoring process and produce monitoring reports/results to be submitted to the MQD for use in its ongoing data monitoring.

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 (2020) 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 survey activities as they were included in the QI health plans' sampling; therefore, there are no separate CAHPS or Provider Survey results related to CCS members.

Excluding 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 2020 compliance reviews were carried over to 2021. The specific compliance review findings and recommendations were reported in the 2020 EQR Report of Results. As appropriate, HSAG conducted technical assistance for the health plans and conducted the follow-up assessments of compliance. All health plans successfully addressed the findings and recommendations from the 2020 compliance reviews in 2021. The specific results of the 2021 reevaluation of CAPs are found in Section 3 of this report.

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

2020 NCQA HEDIS Compliance Audit Recommendations

The auditors did not have any recommendations for AlohaCare QI.

Improvement Activities Implemented

Not Applicable.

2020 HEDIS Performance Measure 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 at or above the 90th percentile, indicating positive performance regarding controlling diabetes and well-child visits for infants.

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*

Improvement Activities Implemented

Access to care:

The pandemic has continued to be a challenge into 2021. AlohaCare recognizes that providers are heavily burdened and has attempted to dramatically improve the quality of member-provider interaction by offering vaccination materials and resources, PPE [personal protective equipment], and a variety of access to care grants to providers needing funds to enhance their services at this time.

We 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 [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.

During the pandemic, we have added many new providers including specialty care providers to our network. We have also launched a major value-based arrangement with Queens Clinically Integrated Physician Network (QCIPN) which offers payment in the form of a PMPM [per member per month] payment for engagement of non-attributed, assigned members of all of the network's PCPs, and also offers payment for an ED diversion program. We are working to develop similar agreements with multiple other provider groups and have developed tools that allow these groups to get real-time data on their attributed and assigned lives including information about utilization, and gaps in care.

A new workgroup (Medical Economics) was launched that targets avoidable utilization; the group analyzes cost and utilization and has developed numerous programs aimed at reduction. As a part of this initiative, AlohaCare is looking at the high cost of NICU [newborn intensive care unit] and has launched programs with new community providers that offer proactive mobile services to perinatal members that are resistant to seeking medical care and social services on their own. The medical economics workgroup has also launched a sub-initiative aimed at improving the accuracy of our provider's risk scoring, which should be launched by the end of 2021.

Child Preventive Health:

The pandemic has a tremendous negative influence on children's preventive health, but AlohaCare has implemented several interventions in 2021 to improve these measures. Recognizing that pediatric vaccination was critical throughout the year, and that COVID vaccination was critical for eligible children, AlohaCare developed vaccination materials to be offered to providers and mailed to member homes. Three campaigns went out in 2021 including pediatric vaccination, COVID vaccination, and flu vaccination. Provider packets included these materials and stickers, and brochures for patients. They

included guidebooks with resources helping providers use motivational interviewing with parents and families around vaccination.

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 within 3 to 6 years old and adolescents who missed their annual PCP checkup. Live telephonic calls were made to assist with scheduling visits.

AlohaCare continued a member incentive program to target noncompliant members eligible for these measures, and in March 2021 AlohaCare rolled out their 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 [Early and Periodic Screening, Diagnostic, and Treatment], and our EPSDT coordinator provided extensive outreach to encourage pediatric visits that would include screening, vaccination, and exams.

Women's Health:

AlohaCare implemented several interventions in 2021 to improve measures for women's health. Automated campaign messages via text and IVR were used to educate pregnant members about the importance of screens. Live telephonic calls by lead care managers were made to assist with scheduling visits.

AlohaCare is currently in the process of designing new educational materials related to women's health screenings, which can be mailed in the near future on an annual basis.

In 2021, AlohaCare continued a member incentive program to target noncompliant members eligible for cervical cancer and chlamydia screening, and in March AlohaCare rolled out our Provider Pay for Performance Program, which included incentives for prenatal/postpartum care, cervical cancer screening, and breast cancer screening. Noting that the impact of the pandemic has greatly decreased screening measures, particularly on neighbor islands, AlohaCare has leveraged its relationship with Hawaii's Community Health Centers and with QCIPN to push lists of noncompliant members attributed to those clinics. In addition, AlohaCare has dramatically improved its online population health tools for providers, which allow PCPs to see which patients are noncompliant for the measures noted. These tools help providers by offering actionable patient data and encourage improvement by showing providers their quality scores compared with external benchmarks and like providers.

In 2021 AlohaCare also established new interdisciplinary quality workgroups. The workgroup focused on Clinical Quality Measures recently defined the target populations and conducted a failure modes and effects analysis on the two chosen measures: *Breast Cancer Screening* and *Cervical Cancer Screening*.

Behavioral Health:

AlohaCare staff performed a very successful PIP in 2020 for the 7-day follow-up to behavioral health hospitalization with our partners Adventist Castle, and Care Hawaii. In 2021, we expanded the project to include follow-up by QCIPN, through inclusion in the network's value-based arrangement.

AlohaCare recently hired new behavioral health staff who support this and other initiatives including *CIS* [*Childhood Immunization Status*], and new interventions aimed at improving the way we support pregnant and postpartum members with behavioral health and social health needs. While we continue to support children with special healthcare needs through our EPSDT outreach and coordination, we anticipate doing additional work to support the behavioral health needs of children in the near future.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior recommendations; however, the health plan should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS—Adult Survey

2020 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*. 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 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 to care 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.

Improvement Activities Implemented

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 shares information about member experience surveys with providers and offers tools and supports for close partners like community health centers. Our plan also views member experience as a holistic end-to-end experience, noting that members rarely differentiate their experience of care received by the doctor, pharmacy, and health plan. A poor experience in any area may contribute to a general dissatisfaction with care on the whole. As a result, our plan has taken a multi-pronged approach to improving overall satisfaction.

- AlohaCare 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 Community Health Centers [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.
- AlohaCare has been a strong proponent of data integration, with a focus on full integration with all of Hawaii's Community Health Centers who see more than half of our members. AlohaCare pays for a considerable portion of the costs related to the CHC's 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 previous 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 members received outside their walls. This provides a better care experience for members.
- AlohaCare has changed its Medicaid pharmacy benefits manager and outsourced medical transportation to highly respected vendors who we believe will provide an exceptional standard of care to our members in a more efficient way. Our plan tracks and trends the performance of these vendors to ensure the experience has improved.
- AlohaCare is providing more, and better, communication with members. Not only are we providing more outreach in ways our members have stated that they prefer to be communicated with, but our plan has continued and enhanced a member incentive program. AlohaCare has added new value-added services, which it has promoted with members via text and online as well as through our member newsletter. We have updated website and social media functionality, and call center processes. Currently, the call center is providing a pilot call-close survey to get feedback about member happiness with our ability to meet their needs. The call center has renovated its recordings and phone tree to create less wait time and lower possibility of being misrouted. Integration of internal information systems has made it easier for call center staff to answer member questions without placing the member on hold for a long time, or having to call the member back.

Finally, throughout the pandemic, AlohaCare has provided extensive support to community members, offering high-touch care to members with COVID-19, and members whose lives have been impacted by the virus due to job loss, decreased income, and other changes in circumstance. Our presence has been warmly felt across all our island communities; in partnership with CHCs and other community partners, we have offered food, PPE, and a variety of other essential needs to members and non-members. Our hope is that by improving communications and relationships with providers, supporting clinics, improving internal processes, and providing a better overall product, the member experience will improve across every domain.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior recommendations; however, AlohaCare QI should continue to implement interventions to improve member satisfaction.

HMSA QUEST Integration (HMSA QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2020 NCQA HEDIS Compliance Audit Recommendations

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.

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.

2020 HEDIS Performance Measure 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 at or 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*

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 urgent care providers located in clinics on Oahu, Maui, Hawaii Island, and Kauai. The urgent care clinics offer extended weekday, weekend, and holiday hours and can treat a wide range of conditions, except life-threatening emergencies.

HMSA also pays for QI members to travel between islands for non-emergency medical care.

Additionally, HMSA continues to provide member education materials, such as articles in our quarterly member magazine, online member magazine, or QUEST Integration member newsletters, to increase member awareness of their care options and to help members understand their role in obtaining appropriate care in a timely and satisfactory manner.

Children's Preventive Health:

HMSA has two programs, Payment Transformation and FQHC/RHC [federally qualified health center/rural health clinic] Pay-for-Quality, in which part of a provider's compensation is tied to specific quality metrics.

HMSA's quality payment programs include a measure for *Childhood Immunizations* which encompasses Hepatitis B and IPV. This program measure also includes adolescent immunizations which encompass Tdap and meningococcal.

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 and continue in 2021.

In 2021, HMSA continued to partner with Icario to create a rewards program for QI members. The program, called HMSA My Health Rewards, includes member rewards for completing child and adolescent well visits with immunizations. For 2021, HMSA enhanced participation in the program by directly enrolling members eligible for prenatal and postpartum care rewards into eligibility for early childhood well-visits after delivery.

Care for Chronic Conditions:

HMSA has been working to design a program founded on the concept that all health 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 other HMSA resources like CDEs (certified diabetes educators) and combined them with current health coordination processes like complex case meetings.

In a disease management/self-management support program, members would need to be seen frequently. HMSA has taken that into account and will utilize the case acuity function in the Coreo platform to allow health 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.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior recommendations; however, the health plan should continue to implement interventions aimed at improving member access to care and health outcomes. In addition, HMSA QI should explore other means to obtain and integrate behavioral health data from the State's PIHP, 'Ohana CCS.

CAHPS—Adult Survey

2020 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*. 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 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 to and timeliness of care 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.

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.

In addition, HMSA is very interested in understanding our members concerns regarding receipt of healthcare from our providers as well as their interaction with us. HMSA conducted a QI CAHPS Drill Down Survey for our adult population that is designed to measure member experiences with regard to key indicators in the Medicaid CAHPS Survey. This will allow HMSA to drill down and obtain additional data points on members' experience for the global rating which we saw a decline in from previous years. Fielding from this survey ended in September 2021, and results will be provided to HMSA for improvement opportunities in October 2021.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior recommendations; however, HMSA QI should continue to implement interventions to improve member satisfaction.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2020 NCQA HEDIS Compliance Audit Recommendations

The auditors did not have any recommendations for KFHP QI.

Improvement Activities Implemented

Not Applicable.

2020 HEDIS Performance Measure 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) meeting or 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*

Improvement Activities Implemented

Adolescent Well-Care Visits:

To address limited access for well-care visits:

- Offered Saturday physical examinations
- Offered sports clinics
- Adjustments made to schedules to accommodate adolescent physicals
- Recruitment efforts ongoing for additional providers

Childhood Immunization Status (HiB) and Immunizations for Adolescents (Tdap):

- Vaccines offered at all well-visits
- Due to the rising number of vaccine refusers, vaccine hesitance addressed at each visit.
- Recruitment efforts ongoing for additional providers

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior recommendations; however, the health plan should continue to implement interventions aimed at improving member access to care and health outcomes, specifically pertaining to children's preventive care.

CAHPS—Adult Survey

2020 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*. 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 it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.		✓	

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

Improvement Activities Implemented

Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their health plan.

The KPQI Team actively monitors timeliness of access to care for our QI patients. In collaboration with the Health Care Team, the KPQI service coordinator is there to ensure our members get the care needed. As a result, our 2020 CAHPS survey indicates that 90.8 percent of respondents reported that they usually/always find ease of getting the care, tests, or treatments they needed. We continue our focus on improving access to care that is convenient for our members by optimizing easy-to-use online care options via kp.org or by calling in to our appointment call center.

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

Caring and compassion are core values of our provider practice and set the standard for our member experience. This is reflected in our 2020 CAHPS survey where 94.76 percent of respondents indicated that their personal doctor spent enough time with them. In fact, all other questions focused on doctor communication (explained things, listened carefully, and showed me respect) scored above 95 percent of respondents indicating usually/always. We will continue to monitor these ratings to ensure we continue to provide a consistent and positive member experience.

Respondents reported that forms from their health plan were often not easy to fill out.

Our business team continues to streamline processes for completing forms. This includes members being able to access forms online via kp.org, using technology to complete forms in care delivery, and reviewing forms with our Patient and Family Centered Care Advisory Council for ease and readability. As a result, our 2020 CAHPS survey indicated that 98.32 percent of respondents indicated that health plan forms were easy to fill out.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior recommendations; however, KFHP QI should continue to implement interventions to improve member satisfaction.

'Ohana Health Plan QUEST Integration ('Ohana QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2020 NCQA HEDIS Compliance Audit Recommendations

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

Improvement Activities Implemented

Not Applicable.

2020 HEDIS Performance Measure 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 at or above the 75th percentile, indicating 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*

Improvement Activities Implemented

2021 Medicaid Partnership for Quality (P4Q) Program

- 'Ohana's 2020 Medicaid Partnership for Quality (P4Q) recognizes providers who collaborate with 'Ohana to deliver high-quality care. Through the P4Q program, providers are able to obtain financial incentives to close care gaps. '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.

2021 Healthy Rewards

- The 'Ohana Health Plan Healthy Rewards Program incents 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 and 30 months, Prenatal Timeliness, Postpartum Care, Diabetes HbA1c Test, Diabetes annual eye exam, Cervical Cancer Screening, Breast Cancer Screening, Behavioral Health Follow Up, and Substance Abuse Initiation and Engagement. In addition, the program incents eligible members to receive tobacco cessation counseling and new member Health Risk Assessment (HRA) completion with a PCP visit.

2021 Continuity of Care (CoC) Program

- The CoC program is a risk adjustment bonus program for 'Ohana providers. It is designed to support outreach to members for annual visits and condition management, which in turn helps better identify members who are eligible for case management programs. The program achieves this goal by increasing PCP visibility into members' existing medical conditions for better quality of care for chronic disease management and prevention. Providers earn incentive payments for proactively coordinating preventive medicine, thoroughly addressing all of the patients' current conditions to improve health, and providing appropriate clinical quality of care. Members benefit from this program by receiving more regular and proactive assessments and chronic condition care. The 2021 program incorporates appointment agendas and HEDIS and pharmacy measures in one

comprehensive program. Providers are eligible for a bonus for each completed appointment agenda with verified diagnoses via claims.

Focused Call Campaigns

- 'Ohana's provider practice coordinators (PPCs) 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 PPC is unable to reach the member by telephone after multiple attempts, an unable to contact letter for established patients is sent which identifies services that are overdue and asks members to contact their PCP (name and phone number included in the letter). The letters also include information on how to schedule transportation with the PPC'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 members with information regarding how to change their PCP if needed.

Disparity Toolkits

- 'Ohana's Disparity Toolkits incorporate an evidence-based framework for use when communicating directly with members (in-person, over the phone, and via email); developing materials (written, electronic, and recorded); and developing interventions, as necessary for certain populations. Components within the toolkits include messaging checklists, intervention recommendations, and multicultural messaging charts.

In-Home Assessments

- 'Ohana recognizes a small subset of the population may have additional barriers which prevent either an in-person or telehealth visit. Starting in September 2021, we are launching an in-home assessment initiative to further address any access to care or members who may have had a historical diagnosis that warrants further attention.

Access and Risk-Adjusted Utilization:

- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *45–64 Years*, and *Total*

Improvement Activities Implemented in 2021:

- Quality practice advisors (QPAs) identify providers' appointment time frames and conduct provider education on annual preventive visits in accordance with specified age groups and time frames.
  - Key providers with access issues are identified and QPAs and Provider Relations conduct specific Access Coaching sessions.
- 'Ohana's provider practice coordinators (PPCs) are encouraging members to conduct their annual preventive visits by engaging members via call campaigns, mailers, and member incentives.

- ‘Ohana will be launching in-home assessment visits starting in September 2021.

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*

Improvement Activities Implemented in 2021:

- Birthday cards are sent to pediatric and adolescent members turning ages 1 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 ages 1 to 20 who 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.
- ‘Ohana’s PPCs 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.
- Corporate Quality Care Gap text campaign to parents/guardians in April and August 2021 targeted to noncompliant 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.*
- Text messages sent to caregivers of child members ages 36 months to 8 years through GoMo Health: Growing Steps (2 messages/week). Topics covered:
  - Child language and literary development
  - Wellness check-in guidance
  - Nutrition
  - Periodic screenings
  - Physical activity
- Inbound IVR messaging and App Push Notification: Obtain shots for return to school for the following measures in July 2021: *Childhood Immunization Status* and *Immunizations for Adolescents.*
- ‘Ohana’s QPAs and/or PPCs provide providers with noncompliant member lists.
- Providers are mailed a noncompliant member lists for members not seen for more than 120 days from enrollment.

- Medicaid Partnership for Quality (P4Q) Program:
  - Provider receives $50 incentive for every member that completes *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*
  - Provider receives $50 incentive for every member that completes *Childhood Immunization Status—Combination 10.*

Women's Health:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*

Improvement Activities Implemented in 2021:

- 'Ohana's PPCs are encouraging members to conduct their breast cancer and cervical cancer screening by engaging members via call campaigns, mailers, and member incentives.
- Corporate Quality Care Gap Text campaign to remind members of their screening and tests in March, May, and July 2021.
- Inbound IVR messaging Call to Action: Schedule breast and/or cervical screenings in Sept 2021.
- Provided education to OB/GYN providers using Women's Health HEDIS Toolkit, which includes all women's health-related HEDIS measures.
- Medicaid P4Q Program: Provider receives $25 incentive for *Cervical Cancer Screening.*
- Disparity Toolkit created specific to Filipino and Chuukese populations which provides cultural insight and considerations when addressing members directly about their screenings or when sending specific messaging to them about their preventive care.

HSAG Assessment

HSAG has determined that 'Ohana QI has addressed the prior recommendations; however, the health plan should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS—Adult Survey

2020 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*. '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 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 to and timeliness of care 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.

Improvement Activities Implemented

To address areas of improvement related to access to and timeliness and quality of care, the following improvement activities were implemented in 2021:

Provider Focused Activities

'Ohana Health Plan has integrated CAHPS conversations into our regular quality meetings with strategic provider partners. During these meetings 'Ohana staff, primarily QPAs, educate providers on the importance of CAHPS, disseminate best-practice guidelines, and present and review provider CAHPS data and scorecards.

In addition to provider meetings, 'Ohana Health Plan has conducted analytics including sentiment analysis across our provider network to identify key drivers of potential dissatisfaction. A special

intervention, based on this sentiment analysis, is being conducted and will involve additional meetings with providers to review the importance of CAHPS, particularly focused on access to care.

Finally, ‘Ohana Health Plan published newsletter articles in the Provider Newsletter to educate its providers on the following CAHPS-related topic:

- “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.

Member Focused Activities

‘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.
- “Don't Wait for Care: Waiting Room Alternatives”: Educates members on services available to them which might better meet their immediate and urgent care needs.
- “Pharmacy Benefits: Help Us Coordinate Your Care”: Educates members on coordination of benefits to help ensure they have accurate processing of drug claims at point of sale.

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.

Starting in September 2021, in addition to CAHPS conversations with providers, ‘Ohana’s Provider Services and Quality Improvement teams conduct an Access Coaching session with key providers, which identifies the impact of access to care on provider practice and helps providers to set goals for

reviewing best practices or creating action plans, and reviewing progress on access to care. During this session, ‘Ohana identifies barriers to member care and provides provider education on best practices for improving member access and perception of overall experience.

Customer Service

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 agents who score the highest in quality and productivity and meet service levels.

Additionally, regular training to customer service staff is conducted on a wide range of consumer experience topics.

Operational Activities

In 2021, ‘Ohana Health Plan established a Member Experience Workgroup comprised of leadership throughout the health plan with a mission to drive an increased awareness of member experience throughout the organization. This workgroup serves as a forum to identify and address potential opportunities for increasing member experience, decrease silos or friction which may result in poor member experience, and share best-practices and lessons learned related to best-in-class member experience.

Member experience has also been a topic presented and emphasized in all staff Town Hall meetings. All staff were educated on what CAHPS is, why it is an important measure of member experience, and what role they play in driving an excellent member experience. Further trainings have been made available and promoted to all staff within the organization.

HSAG Assessment

HSAG has determined that ‘Ohana QI has addressed the prior recommendations; however, the health plan should continue to implement interventions to improve member satisfaction.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2020 NCQA HEDIS Compliance Audit Recommendations

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

Improvement Activities Implemented

Not Applicable.

2020 HEDIS Performance Measure Recommendations

Based on HSAG's analyses of UHC CP QI's 31 measure rates comparable to benchmarks, nine measure rates (29.0 percent) ranked at or above the 50th percentile, with three of these rates (9.7 percent) ranking at or above the 75th percentile and three of these rates (9.7 percent) meeting or 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*

Improvement Activities Implemented

Access and Risk-Adjusted Utilization:

- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* and *45–64 Years*

The current UHC CP QI Member Handbook includes the following information to facilitate members' access to care for Preventive/Ambulatory Health Services:

- A section titled, "How to get health care" is included and provides details on how members can choose or change their PCP.
- Members are encouraged to schedule their first appointment with their PCP and informed that checkups are important even if members do not feel sick. Through the Advocate4Me service delivery model, UHC CP QI can assist members with scheduling appointments with providers.
- The 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.
- A table listing covered preventive health services is included in the Handbook and includes the age range and frequency for recommended services.
- Information on available transportation services to and from healthcare appointments is provided.
- Telehealth providers continue to be available to members for urgent care and non-emergency primary care visits. The UHC CP QI call center assists with referrals to telehealth providers as needed.
- The winter 2021 edition of the UHC CP QI member newsletter, *Health Talk*, included an article, "Healthy start: Options for seeing your PCP," that encouraged members and all their families to schedule an annual well visit appointment with their PCP. The article also mentioned telehealth as a possible alternative to an in-person PCP visit.
- The spring 2021 edition of *Health Talk* had an article, "Your partner in health," that informed readers about the role of a PCP and when members should see one. The article also mentioned teenagers' healthcare needs and how members can switch to a new PCP.
- UHC CP QI participated in a national telehealth email initiative in December 2020 to drive awareness of telehealth visits with a PCP, help drive effectiveness of gap closures as a result of virtual care, and build general awareness of where to get care. Emails were structured to address telehealth as a priority, followed by additional options for care and important topics to remember for the next visit. There were three customized emails for three different segments of the member population: child, family, and elderly.
- UHC CP QI is participating in the 2021 UnitedHealthcare National Telehealth Email Campaign. Emails will be sent to targeted members to drive awareness of telehealth as an alternative to in-person visits with a PCP and to build general awareness around how members can access care. The email will link members to a virtual visit checklist to help them prepare for their telehealth visit.

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*

- The Member Handbook provides information on covered EPSDT Services available to members under the age of 21, including preventive exams/well-visits and immunizations. Support is available as needed to schedule appointments and coordinate transportation to and from appointments.
- The winter 2021 edition of *Health Talk* had an article, "Stay on schedule: Vaccines are important even during COVID-19." The article urged parents/guardians to keep up to date on immunizations for their children.
- The spring 2021 edition of *Health Talk* included a short message to readers to let them know that immunizations are safe for children and that numerous studies have found no link between vaccines and autism.
- UHC CP QI launched its OmniChannel Program in May 2021 targeting members with gaps in care including immunizations for children (*CIS*) and immunizations for adolescents (*IMA*). The OmniChannel program is designed to outreach to members using their preferred mode of communication: email, IVR calls, and/or text messages. The program rolled out with emails and IVR calls only but will expand to text messages in the future. The program is ongoing and will run year-round.
- UHC CP QI continues to send EPSDT mailings to eligible members in 2021. The mailings include welcome and birthday postcards and delinquent visit notifications.
- UHC CP QI is participating in the 2021 Member Rewards Program (MRP). The MRP offers a sample of eligible members a $25 gift card for closing a care gap. Well-child visits for ages 3 to 21 years (*WCV*), *IMA Combo 2*, and *CIS Combo 10* are included as incentivized measures.
- The Healthy First Steps rewards program is a free online wellness program for pregnant women and mothers who have given birth within the past 15 months. The program offers rewards for well-child visits at 6 months and 15 months (as well as for prenatal and postpartum care).
- UHC CP QI is also participating in the Pfizer-sponsored Child Immunization Program, which reminds parents/guardians of missed dose vaccines for their children at ages 6 months, 8 months, and 16 months through IVR calls and mailed postcards. Reminders for a well visit during a child's first year are also included in the program, starting at age 10 months.
- UHC CP QI is participating in an HPV email campaign in 2021. Emails are sent to members or parents/guardians to encourage members ages 9 to15 to obtain HPV screening and vaccinations prior to their 15th birthday. The email provides education and resources to support informed decision making.
- The CP-PCPi (Community Plan-Primary Care Professional Incentive) program offers a financial incentive to practitioners for closing HEDIS care gaps for UHC CP QI members. *Well-Child Visits in the First 30 Months (W30)* and *WCV* are incentivized measures in the 2021 program, with a $100 bonus to practitioners for each gap closed.
- The UHC CP QI Quality Clinical Practice Consultants (CPCs) review with their assigned providers the status of their *CIS*, *IMA*, *W15* and *WCV* measurements during provider meetings and through emails. The CPCs and providers discuss ideas and strategies to improve measure performance, and the CPCs also clarify any coding questions for billing as needed. A new EPSDT coordinator was hired in May 2021 and has been attending provider meetings with the CPCs to introduce herself, as she will transition to take over the EPSDT sections from the CPCs in 2021.

- The EPSDT coordinator will be educating providers on the newly revised DHS 8015 form and answering any questions or concerns from providers on the new form.
- UHC CP QI created an EPSDT coordinator assistant position to assist the EPSDT coordinator with EPSDT activities. The EPSDT coordination assistant position was filled in July 2021.
- UHC CP QI created The Wellness Project to provide health education for members and the community via live member wellness workshops. Member wellness presentations are made available following the workshops on the UHC CP QI's public website and the member portal. In August 2021, the EPSDT coordinator participated in a workshop for UHC CP QI members that focused on EPSDT. The EPSDT coordinator presented on EPSDT, vaccinations, and other information to increase members awareness of their EPSDT benefits. A recording of the presentation is accessible for members to listen to at any time.
- The UHC CP QI EPSDT coordinator provided education for health coordinator managers (HCMs) related to EPSDT. The training focused on the purpose and importance of ESPDT and gap closures. The EPSDT coordinator trained the clinical staff on the process for checking for EPSDT gaps in the clinical platform as well as talking points and documentation to add to the clinical system.
- UHC CP QI CPCs provide ongoing training for facilities such as Hamakua Health Center and Community Clinic of Maui focusing on EPSDT. Any training already conducted included 1:1 education on EPSDT with the pediatric staff. Additionally, UHC CP QI shares resources and links for EPSDT as part of recurring monthly meetings with providers.

Women's Health:

- *Cervical Cancer Screening*
- The Member Handbook includes the age range and frequency for different types of covered cervical cancer screenings.
- *Cervical Cancer Screening (CCS)* is an incentivized measure in the 2021 CP-PCPi Program, with practitioners receiving a $100 incentive for each gap closed.
- CCS is also part of the 2021 MRP. Members can receive a $25 gift card for *CCS* gap closures.
- The OmniChannel program that launched in May 2021 included emails and IVR calls to members with gaps in care for *CCS*. The program rolled out with emails and IVR calls only but will expand to text messages in the future. The program is ongoing and will run year-round.
- UHC CP QI participated in the 2021 National Women's Email campaign in May 2021, in which emails were sent to eligible members that encourage completion of *CCS*, as well as breast cancer screenings.
- UHC CP QI CPCs review the *CCS* measure with providers and explain the importance of gap closure, how gaps are closed, and documentation requirements to meet measure criteria. The CPCs emphasized the importance of *CCS* at provider visits in September as part of cancer awareness. Additionally, the CPCs participated in a review of *CCS* with Bay Clinic in July 2021 to support the organization's measure of the month activities.

Behavioral Health:

- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- In 2021, UHC CP QI recruited for and hired a behavioral health (BH) clinical practice consultant (CPC). This position is new to the health plan, and it was developed to offer BH providers additional support in addressing the *Follow-Up After Hospitalization for Mental Illness (FUH)* measure.
- *FUH-7 Days* is an incentivized measure in the 2021 CP-PCPi Program, with PCPs receiving a $50 incentive for each gap closed.
- There is also a $50 incentive for BH providers for each *FUH* follow-up visit within seven days of discharge.
- UHC CP QI is continuing its program in which it donated computers to homeless centers and community-based organizations in Hawaii such as Achieve Zero to allow members experiencing homelessness to complete follow-up visits through telemental health. A telemental health training deck was also created to help the members when setting up follow-up appointments on a virtual platform. The telemental health guide will be distributed to community-based organizations when it is approved by MQD to help members connect with their providers virtually.
- Outpatient BH providers are contracting to reserve a block of time specifically to be available for *FUH* telemental visits. This was piloted in 2020 and was an intervention UHC CP QI tested in the DHS-assigned PIP on *FUH*. UHC CP QI is continuing with this intervention following the PIP cycle.
- UHC CP QI will implement a member incentive in Q4 2021 (pending MQD approval) to reward members for completing a follow-up appointment within 7 days of discharge.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior recommendations; however, the health plan should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS—Adult Survey

2020 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*. 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 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**
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 an area 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.

Improvement Activities Implemented

Based on UHC CP QI's results on the 2020 CAHPS Adult Survey, the following activities were implemented in 2021:

Access and timeliness: Receiving care needed right away as soon as needed (Getting Care Quickly)

- UHC CP QI added information to the Member Handbook related to timeliness of care including 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 2021 edition of the UHC CP QI member newsletter, *Health Talk*, included an article, "Healthy start: Options for seeing your PCP," that mentioned telehealth as a possible alternative to an in-person PCP visit.
- UHC CP QI staff continues to conduct outreach to members to provide education and support regarding telehealth, COVID-19 prevention, and vaccination information. The UHC CP QI call center, for example, has an ongoing workflow to provide information to members on testing centers and locations to receive a vaccine.
- UHC CP QI continues to work on expanding its provider network for both PCPs and specialists and works with its credentialing delegate to minimize administrative burden on providers and better streamline the credentialing and contracting process.
- Information on the transportation benefit available to members is included and promoted in the member newsletter (*Health Talk*), in member Welcome Letters, in the Member Handbook, and on the member portal.
- UHC CP QI members can access a telehealth provider including at night, on weekends, and during holidays. Members can use telehealth providers for urgent care and non-emergency primary care visits. The UHC CP QI call center assists with referrals to telehealth providers as needed.
- Consistent with Section 1557 of the Patient Protection and Affordable Care Act, UHC CP QI continues to include language blocks with its written materials for any members who experience language barriers. Language assistance is available for members with language barriers to assist with timely access to providers.
- The Wellness Project will provide member training called, "Taking Charge of My Technology." The training will explain the benefits of using digital technology in managing care, and it will include information and demonstrations on NurseLine and MyChart to increase member awareness on health access options available to them (such as telehealth). The training is in development and is scheduled to occur in December 2021.
- UHC CP QI is in the process of developing a "Getting Care Quickly" member flyer. The flyer will be added to a future edition of the member newsletter (*Health Talk*) and will also be shared with community-based organizations.
- UHC CP QI is updating its Health Coordination Referral Form to give members and providers more comprehensive referral options. The form enables providers and agencies to refer members directly to Clinical Services departments such as Health Coordination, Community Integration Services (CIS), Hāpai Mālama, and Population Health Management. The referral form captures social risk factors and social determinants of health. The form is being made available on the provider portal for providers to view and download.
- UHC CP QI continues to provide telehealth education to its providers and members and works collaboratively with other MCOs on a telehealth implementation plan.

Access and timeliness: Easy to get care, tests, or treatment needed (Getting Needed Care)

- The winter 2021 edition of the UHC CP QI member newsletter, *Health Talk*, included an article, "Healthy start: Options for seeing your PCP," that mentioned telehealth as an alternative to an in-person PCP visit.

- Timely access to care information was included in the Member Services policies and job aids, and scripting was also updated to capture this information.
- In the member survey for the Timely Access Report (TAR), the following question was added: "Would you consider telehealth for immediate access to care? (Yes/No/Unsure)." A majority of responses indicated openness to using telehealth as an option for immediate access to care. UHC CP QI will therefore continue to promote and expand telehealth options to its members.
- At the Provider and Home and Community-Based Services (HCBS) Provider Town Hall held in April 2021, the UHC CP QI chief medical officer provided information on telehealth, the TAR survey results, appointment time frames, Project ECHO [Extension for Community Healthcare Outcomes], and more. Additional provider town halls will be scheduled for Q4 2021.
- As members call in to UHC CP QI, Member Services staff educate them on access to care options, including telehealth opportunities. Staff also make referrals to telehealth providers as appropriate.
- UHC CP QI utilizes a Navigator team that focuses on supporting DSNP [dual-eligible special needs plan] members. DSNP Navigator team members receive alerts based on claims data when member gaps are identified. DSNP Navigators conduct member outreach to assist with gap closure as needed.
- The UHC CP QI Network team is actively recruiting specialists and working with the credentialing vendor to credential needed specialists, reduce administrative burden for providers, and streamline the credentialing and contracting process.
- The UHC CP Prior Authorization team provides biweekly files to the Network team to identify referrals to out-of-network providers. The Network team utilizes the file to conduct outreach to providers for contracting.
- UHC CP created a telemental health guide which is currently pending MQD approval. The telemental health guide will assist members in finding care and scheduling appointments. It offers step-by-step information for both members and providers to guide them on how to connect with a virtual platform. The guide will be distributed to BH virtual providers and community-based organizations.
- UHC CP QI is continuing its partnership with Waimanalo Health Center on the Traditional Methods of Healing Pilot Program in 2021. Through this program, a Native Hawaiian practitioner and PCP collaborate on a person-centered approach to integrate traditional Native Hawaiian methods of healing and Western medicine from the PCP to provide needed care.

Quality of Care: Personal doctor seems informed and up to date about care received from other health providers (Coordination of Care)

- UHC CP QI will provide training as part of the Wellness Project on "Taking Charge of Coordinating My Care." The training will offer members helpful tools to help them take charge of coordinating their care, keep track of their prescriptions and doctors, ensure their medical records are shared among their doctors as they see fit, and empower members to advocate for their own care. The training is scheduled to occur in October 2021.
- UHC CP QI is distributing to its providers an overview of both the CAHPS Survey and HOS [Health Outcomes Survey]. The material highlights the key survey measures and explains why the surveys

are important not only to the health plan but to its providers as well. Distribution started in June and is currently ongoing as part of UHC CP QI's provider education efforts.

Quality of Care: Customer Service gives the information or help needed (Health Plan Customer Service)

- A questionnaire developed and piloted in 2019 to gather member feedback on CAHPS® member experience topics is being used at quarterly Member Advisory Group (MAG) meetings. The MAG meetings resumed in Q1 2021 after no meetings were held in 2020 due to the COVID-19 pandemic. UHC CP QI will continue to use the questionnaire to gain member insight on member satisfaction.
- During the 2021 MAG meetings, UHC CP QI staff provided members with information on the Advocate4Me (A4Me) model and the services that Customer Service Advocates (CSAs) provide. Services mentioned include assistance in finding a provider and scheduling appointments; arranging transportation for medical care; connecting to a Health Coordinator or other support resources; coordinating interpreter services if needed; and help with billing issues. UHC CP QI staff emphasized to members that CSAs are firmly committed to helping them resolve any healthcare system issues or concerns they may have.
- UHC CP QI continues to conduct Self-Direct Provider Orientations to educate self-direct providers on processes and guidelines related to timesheet completion and submission deadlines, payment turnaround times, and time frames for a UHC CP QI self-direct team response.
- UHC CP QI updated its Member Services Job Aids to align with State requirements. For example, job aids for PCP/specialist searches were updated with appointment-setting time frames to ensure that UHC CP QI staff set up member appointments in accordance with timely access standards.
- UHC CP QI expanded its support for members with limited English proficiency (LEP). UHC CP QI leverages its growing DSNP Navigator team to support QI members who need language assistance. UHC CP QI also has bilingual individuals on staff who speak prevalent non-English languages such as Vietnamese and Korean. UHC CP QI continues to recruit for additional bilingual staff as needed.
- UHC CP QI continues to educate its Member Services staff of the expectations of its Advocate4Me/Navigate4Me Service Delivery models. The Advocate4Me service delivery model is designed to improve the member experience when properly executed. This is accomplished by minimizing the need for members to make repeated calls to the health plan for assistance. The goal is to make members do less work in receiving the care or assistance they need. Also, UHC CP QI continues to promote the use of compassion techniques in member interactions to improve member satisfaction with UHC CP QI Customer Service.
- UHC CP QI is utilizing a User Experience Survey (UES) automated survey at the end of calls to identify member dissatisfiers. Prior to May 2021, members were required to opt-in in order to participate in the survey. In May 2021, UHC CP QI removed the opt-in requirement and opened participation in the UES survey to all members.
- Staff feedback is gathered on an ongoing basis to identify pain points that may adversely impact service provided to members. For example, members expressed concern with UHC CP QI making too many phone calls for the same issue. UHC CP QI determined that the issue was related to an additional layer of outreach calls for annual wellness. UHC CP QI suppressed the additional layer of

outreach once it was determined that this layer caused member abrasion. UHC CP QI works on process improvements such as this on an ongoing basis to improve the member experience.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior recommendations; however, the health plan should continue to implement interventions to improve member satisfaction.

'Ohana Community Care Services ('Ohana CCS)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2020 NCQA HEDIS Compliance Audit Recommendations

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

Improvement Activities Implemented

Not Applicable.

2020 HEDIS Performance Measure 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 at or 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*

Improvement Activities Implemented

Access and Risk-Adjusted Utilization

- *Ambulatory Care—Total (per 1,000 Member Months)—ED Visits—Total*

Integration Activities with Community-Based Organizations

- ER [emergency room] utilization data are reviewed regularly and identify high utilizers for case presentation at Interdisciplinary Care Team meetings. 'Ohana CCS collaborates with BH case managers and facilities on action plans for high ER utilizers as well as for effective discharge planning and community stabilization for monitoring.
- The ER utilization for CCS membership is presented quarterly at the 'Ohana Health Plan QIC (Quality Improvement Committee) to address improvement efforts on high ER utilizers.
- In 2021, the CCS team began collaborating with AMHD [Adult Mental Health Division] and Mental Health Emergency Workers (MHEW) program to review members who were involuntarily hospitalized by law enforcement on a frequent basis to discuss action plans and resources/coordination that can help stabilize and reduce their frequency of crises. Through these meetings, we aim to eliminate gaps in care and address any barriers to optimal health outcomes.
- The MHEW statute through the Department of Health (DOH) helps to determine if members need involuntary hospitalization at Queens Medical Center (QMC).
- In addition, the CCS team has monthly meetings with the social work manager of one of highest-volume ER facilities in the State (Queens Care Coalition) to discuss high utilization and collaborate on action plans which include crisis and ER diversion strategies and prompt follow-up for those members when they leave the emergency department. We also require CMs [case managers] to respond to members in the ER or in crisis within 1.5 hours, so CCS team will be monitoring this to see if this will help to divert members who may be utilizing the ER unnecessarily.
- *PIP FUM: Follow Up Post Hospitalization within Seven (7) Days*
- From 2019 to 2020, the CCS team conducted a PIP on follow-up post ED visit for mental illness. The measurement period began around Q2 of 2020. The intervention efforts were on providing a timely ER census, increasing communication between CCS team CM liaisons and supervisors of PIP-selected CBCMs (Community-Based Case Management Agencies), Aloha House and Hope Inc., to monitor and closely provide member support on those who visit the ER for mental illness until the member completes a seven-day follow up. The project resulted as successful and in an effective intervention that CCS team exceeded the SMART Aim goal by 0.84 percent.

Behavioral Health

- *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*

Member and Provider Education

- In 2021, 'Ohana Health Plan (Pharmacy, Quality, and CCS team) published articles educating members on depression and the importance of medication adherence in 2nd and 3rd quarter. In 4th quarter, the team is publishing an article to inform CCS members on the community support group specifically on anxiety and depression via online on a weekly basis. The idea to publish about the support groups available in our community was derived from 'Ohana Health Plan's CCS Member Matters Advisory Committee. One of our members addressed that it may be helpful for members to learn about the activities they can join in the community for support with depression and lifestyle adjustments from COVID.

- As antidepressants are prescribed in both PCP and BH provider offices, in Q2 and Q3, ‘Ohana Health Plan published several provider newsletters about the importance of working together and at what point PCPs should refer members to BH services as ‘Ohana Health Plan recognizes that due to stigma particularly in Hawaii, members in this market refuse to see BH providers. Therefore, PCPs often end up treating members through medication.

Data Sharing With CBCMs

- ‘Ohana Health Plan (Pharmacy, Quality, and CCS team) began producing the pharmacy report on a biweekly basis in efforts to identify members who are prescribed antidepressants. In Q4, Quality will develop a report utilizing the pharmacy claims report to identify AMM [Antidepressant Medication Management] eligible members earlier than the existing Quality report becomes available, and CCS will notify the CBCMs on which members are due for their antidepressant medication pick-up. When sending the list of members, the message to CBCMs will address the best practice on discussing medication adherence with their clients. This is a pilot project launching this year.
- Further plans in discussion are to conduct further research on providing better support for members who are in CCS but have Medicare benefits by reaching out internally to other teams in other markets with similar structure and set up with SMI [serious mental illness] membership with Medicare coverage. Additionally, other ideas in discussion are to conduct high-level, low-performing provider surveys as well as administering member surveys to further narrow down the reasons why CCS members are not picking up their medication as possible barriers are broad such as health literacy, substance use, comorbidity, etc.

HSAG Assessment

HSAG has determined that ‘Ohana CCS has addressed the prior recommendations; however, the health plan should continue to implement interventions aimed at improving member behavioral health outcomes.

Appendix A. Methodologies for Conducting EQR Activities

Introduction

In CY 2021, 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 2020 CAPs
- Validation of performance measures (i.e., NCQA HEDIS Compliance Audits)
- Validation of PIPs
- A survey of child Medicaid members using the CAHPS survey
- A survey of a statewide sample of CHIP members using the child Medicaid CAHPS survey
- A survey of QI providers
- An encounter validation study

For each EQR activity conducted in 2021, 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
- How conclusions were drawn

Compliance Monitoring Reviews

Table A-1 delineates the compliance review activities as well as the standards that were reviewed during the current three-year compliance review cycle (2019 through 2021). CAPs from findings during the 2019 compliance reviews were evaluated and resolved by 2020. CAPs from findings during the 2020 compliance reviews were evaluated and resolved in 2021.

Table A-1—Three-Year Compliance Review Schedule

	Year One (2019)	Year Two (2020)	Year Three (2021)
Standard	**Review of Standards**		**CAP Review**
Coverage and Authorization of Services	✓		Review of Standards/Elements
Access and Availability	✓		

	Year One (2019)	Year Two (2020)	Year Three (2021)
Standard	**Review of Standards**		**CAP Review**
Coordination and Continuity of Care	✓		that received a *Partially Met* or *Not Met* score during the 2020 reviews.
Member Rights and Protections	✓		
Member Information	✓		
Member Grievance System	✓		
Provider Selection		✓	
Subcontracts and Delegation		✓	
Credentialing		✓	
Quality Assessment and Performance Improvement		✓	
Health Information Systems		✓	
Practice Guidelines		✓	
Program Integrity		✓	
Enrollment and Disenrollment		✓	

HSAG divided the federal regulations into 14 standards consisting of related regulations and contract requirements. Table A-2 describes the standards and associated regulations and requirements reviewed for each standard.

Table A-2—Compliance Standards and Regulations

Standard Title	Regulations Included
Access and Availability	438.3 438.68 438.206 438.207
Coordination and Continuity of Care	438.208
Coverage and Authorization of Services	422.113 431.211 431.213 431.214 438.114 438.210 438.3 438.404
Credentialing	438.214 42 CFR Part 455 Subpart B State-Determined Requirements

Standard Title	Regulations Included
	NCQA Credentialing and Recredentialing Standards and Guidelines
Enrollment and Disenrollment	438.3 438.52 438.56
Health Information Systems	438.242 45 CFR 164.404 45 CFR 164.408 45 CFR 164.410
Member Grievance System	438.228 438.400 438.402 438.406 438.408 438.410 438.414 438.416 438.420 438.424
Member Information	438.10
Member Rights and Protections (Includes Confidentiality)	422.128 438.10 438.100 438.106 438.108 438.110 438.224
Practice Guidelines	438.236
Program Integrity	438.608
Provider Selection	438.12 438.102 438.106 438.214 438.608 438.610
Quality Assessment and Performance Improvement	438.236 438.240 438.330
Subcontracts and Delegation	438.230

Table A-3 displays the compliance review scores for all health plans during the current three-year review cycle.

Table A-3—Compliance Review Standards and Scores for All Plans Including a Statewide Average Score

Standard and Applicable Review Years	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Average
Coverage and Authorization of Services (2019)	78%	88%	75%	72%	88%	84%	**81%**
Access and Availability (2019)	100%	100%	88%	88%	100%	85%	**94%**
Coordination and Continuity of Care (2019)	90%	90%	80%	100%	100%	67%	**88%**
Member Rights and Protections (2019)	89%	56%	56%	89%	89%	89%	**78%**
Member Information (2019)	82%	64%	59%	77%	73%	76%	**72%**
Member Grievance System (2019)	56%	74%	70%	67%	78%	70%	**69%**
Provider Selection (2020)	90%	100%	90%	100%	100%	100%	**97%**
Subcontracts and Delegation (2020)	95%	100%	70%	95%	100%	95%	**93%**
Credentialing (2020)	100%	99%	99%	100%	100%	100%	**99%**
Quality Assessment and Performance Improvement (2020)	100%	100%	100%	100%	100%	100%	**100%**
Health Information Systems (2020)	100%	100%	100%	100%	100%	100%	**100%**
Practice Guidelines (2020)	100%	100%	100%	100%	100%	100%	**100%**
Program Integrity (2020)	100%	95%	91%	100%	91%	100%	**96%**
Enrollment and Disenrollment (2020)	100%	100%	100%	100%	100%	100%	**100%**

2021 Compliance Review Activities

Objectives

The Balanced Budget Act of 1997 (BBA), as set forth in 42 CFR §438.358, requires that a state or its designee conduct a review to determine each MCO's, PIHP's, and PAHP's compliance with federal managed care regulations and state standards. Oversight activities must focus on evaluating quality outcomes and the timeliness of, and access to, care and services provided to Medicaid beneficiaries by the health plans. To complete this requirement, HSAG conducted a follow-up review of compliance with federal and State requirements for standard areas for which the QI health plans and CCS had implemented required corrective actions based on findings of deficiency from the 2020 compliance reviews. Once each health plan's final compliance review report was produced, the health plan prepared and submitted a CAP for the MQD's and HSAG's review and approval. Once the CAP was approved, the health plan implemented the planned corrective actions and submitted documented evidence that the activities were completed and that the plan was now in compliance. The MQD and HSAG performed a desk review of the documentation and issued a final report of findings once the plan was determined to meet the requirement(s) and was in full compliance.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance monitoring follow-up reviews, HSAG developed a data collection tool to use in the review of each health plan reflecting the areas for required corrective actions. The CAP tool contained the applicable federal and/or State regulation and the action the health plan was required to take to become fully compliant.

HSAG conducted the follow-up compliance monitoring in accordance with the CMS protocol, *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[A-1]

Description of Data Obtained

The health plans used the CAP tool to describe their proposed corrective action, provide the expected date of completion, and list the documents provided to demonstrate implementation of the corrective actions. HSAG assessed the health plans' compliance with federal and State requirements from a wide range of written documents provided by the health plans including committee meeting agendas and minutes, policies and procedures, monitoring reports, and delegation subcontracts and agreements.

Upon the successful completion of all CAP items, HSAG provided the health plan and the MQD with the completed CAP evaluation tool. The plan-specific results are summarized in Section 3 of this report.

How Conclusions Were Drawn

HSAG reviewed all documents submitted by the health plans to evaluate the degree to which corrective actions were implemented. HSAG reviewed the CAP implementation and evaluated whether:

- The corrective actions taken by the health plan were communicated and training was provided to involved providers, health plan staff members, and delegated entities.
- The corrective actions and associated performance results are being monitored and tracked over time.
- The corrective actions appear to be effective and were implemented according to the established time frames.
- Revisions to corrective actions were made if problems were identified.
- Corrective actions resulted in demonstrated improvements in the targeted performance area.

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the Medicaid health plans, HSAG assigned each of the standards reviewed for implementation of corrective actions in 2021 to one or more of those domains of care. Each standard may involve the assessment of

[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: Jan 5, 2022.

more than one domain of care due to the combination of individual requirements within each standard. Table A-4 depicts assignment of the standards to the domains of care.

Table A-4—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Corrective Action Plan Compliance Review Standard	Quality	Timeliness	Access
Provider Selection		✓	✓
Subcontracts and Delegation	✓		✓
Credentialing	✓		
Program Integrity	✓		

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 data collection methodology for the MY 2020 validation activities. Both HEDIS and non-HEDIS measures were validated using the same methodology, which is described in further detail in the following section.

Table A-5—Validated Performance Measures

Performance Measure	QI	CCS	Methodology
Access and Risk-Adjusted Utilization			
Ambulatory Care		✓	Admin
Heart Failure Admission Rate	✓		Admin
Mental Health Utilization		✓	Admin
Plan All-Cause Readmissions	✓		Admin
Children's Preventive Health			
Child and Adolescent Well-Care Visits	✓		Admin
Childhood Immunization Status	✓		Hybrid^
Well-Child Visits in the First 30 Months of Life	✓		Admin

Performance Measure	QI	CCS	Methodology
Women's Health			
Cervical Cancer Screening	✓		Hybrid^
Prenatal and Postpartum Care	✓		Hybrid
Care for Chronic Conditions			
Comprehensive Diabetes Care	✓		Hybrid^
Concurrent Use of Opioids and Benzodiazepines	✓		Admin
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		✓	Admin
Antidepressant Medication Management		✓	Admin
*Behavioral Health Assessment**		✓	Admin
Follow-Up After Emergency Department Visit for Alcohol or Other Drug (AOD) Abuse or Dependence		✓	Admin
Follow-Up After Emergency Department Visit for Mental Illness		✓	Admin
Follow-Up After Hospitalization for Mental Illness	✓	✓	Admin
Initiation and Engagement of AOD Abuse or Dependence Treatment		✓	Admin
Screening for Depression and Follow-Up Plan	✓		Admin
Use of Pharmacotherapy for Opioid Use Disorder	✓		Admin

* Indicates this measure is a state-defined, non-HEDIS measure.

^ KFHP QI received approval from the MQD to report three 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 MY 2020, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*. The measurement period reviewed for the health plans was CY 2020 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-6—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 (e.g., <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 fewer than 360 member months. c. For all risk-adjusted utilization measures, when the denominator is fewer than 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 when permitted by NCQA.

*NA (Not Applicable) is not an audit designation; it is a status. Measure rates that result in an NA are considered Reportable (R); however, the denominator is too small to report.
**Benefits are assessed at the global level, not the service level.

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 MY 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 MY 2019 and to the previous year's rates, where applicable. Measure rates reported by the health plans, but not audited by HSAG in MY 2020, are not presented within this report. Additionally, certain measures do not have applicable benchmarks. For these reasons, the HEDIS MY 2019 rate, relative difference, and MY 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 MY 2020. The MQD Quality Strategy targets for the QI population and CCS program are defined in Table A-7 and Table A-8. For the following measures, lower rates indicate better performance: *Heart Failure Admission Rate—Total, Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%),* and *Ambulatory Care—Emergency Department Visits.*

Table A-7—MQD QI Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target
Access and Risk-Adjusted Utilization	
Heart Failure Admission Rate—Total	1% Improvement Goal
Children's Preventive Care	
Childhood Immunization Status—Combination 3	1% Improvement Goal
Women's Health	
Cervical Cancer Screening	1% Improvement Goal

Measure	MQD Quality Strategy Target
Prenatal and Postpartum Care—Timeliness of Prenatal Care	1% Improvement Goal
Prenatal and Postpartum Care—Postpartum Care	1% Improvement Goal
Care for Chronic Conditions	
Comprehensive Diabetes Care—HbA1c Testing	1% Improvement Goal
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	1% Improvement Goal
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	1% Improvement Goal
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	1% Improvement Goal
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	1% Improvement Goal
Behavioral Health	
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1% Improvement Goal

Table A-8—MQD CCS Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target
Access and Risk-Adjusted Utilization	
Ambulatory Care—Emergency Department Visits	1% Improvement Goal
Ambulatory Care—Outpatient Visits	1% Improvement Goal
Mental Health Utilization—Any Service	1% Improvement Goal
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1% Improvement Goal
Antidepressant Medication Management—Effective Acute Phase Treatment	1% Improvement Goal
Antidepressant Medication Management—Effective Continuation Phase Treatment	1% Improvement Goal
Follow-Up After Emergency Department for AOD Abuse or Dependence—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Emergency Department for AOD Abuse or Dependence—30-Day Follow-Up—Total	1% Improvement Goal

Measure	MQD Quality Strategy Target
Follow-Up After Emergency Department for Mental Illness—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Emergency Department for Mental Illness—30-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1% Improvement Goal
Initiation and Engagement of AOD Abuse or Treatment—Initiation—Total—Total	1% Improvement Goal
Initiation and Engagement of AOD Abuse or Treatment—Engagement—Total—Total	1% Improvement Goal

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care provided by the MCOs, HSAG assigned each of the validated performance measures to one or more of these three domains of care. This assignment to domains of care is depicted in Table A-9.

Table A-9—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Access and Risk-Adjusted Utilization			
Ambulatory Care	NA	NA	NA
Heart Failure Admission Rate	✓		
Mental Health Utilization	NA	NA	NA
Plan All-Cause Readmissions	✓		
Children's Preventive Health			
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Women's Health			
Cervical Cancer Screening	✓		
Prenatal and Postpartum Care	✓	✓	✓
Care for Chronic Conditions			
Comprehensive Diabetes Care	✓		

Performance Measure	Quality	Timeliness	Access
Concurrent Use of Opioids and Benzodiazepines	✓		
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓		
Antidepressant Medication Management	✓		
Behavioral Health Assessment	✓		
Follow-Up After Emergency Department Visit for Alcohol or Other Drug (AOD) Abuse or Dependence	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment	✓		✓
Screening for Depression and Follow-Up Plan	✓		
Use of Pharmacotherapy for Opioid Use Disorder	✓		

NA indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).

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]

In July 2014, HSAG developed a rapid-cycle PIP approach 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 approach is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine what interventions have the greatest impact and can bring about real improvement. CMS agreed that given the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern improvement projects within healthcare settings, a rapid-cycle approach was needed and provided HSAG with approval to use this approach in all requesting states. In 2015, the MQD made the decision to implement the rapid-cycle approach with its contracted MCOs.

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

To document their PIPs, MCOs use five modules with an accompanying reference guide. Prior to issuing each module, HSAG held module-specific trainings with the MCOs to educate them about the documentation requirements and use of specific quality improvement tools for each of the modules. 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

[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, 2021.

[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.

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. In 2021, the health plans completed PIPs that were initiated in 2019 and provided detailed information about the PIP findings, lessons learned, and conclusions in the Modules 4 and Module 5 submission forms. In 2021, the health plans were also engaged in discussions with the MQD for the next PIP topics for 2022 submission.

The PIP topics that were validated in 2021 are included in Table A-10.

Table A-10—Continued PIP Topics in 2021 (Module 4 through Module 5)

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*

Health Plan	PIP Topic
KFHP QI	• *Adolescent Well-Care Visits* • *Follow-Up After Hospitalization for Mental Illness*
‘Ohana 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*
‘Ohana CCS	• *Follow-Up After Hospitalization for Mental Illness* • *Follow-Up After Emergency Department Visit for Mental Illness*

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the Medicaid health plans, HSAG assigned each component reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Other domains were assigned based on the content and outcome of the PIP. This assignment to domains is depicted in Table A-11.

Table A-11—Assignment of PIPs to the Quality, Timeliness, and Access Domains

Performance Improvement Project	Quality	Timeliness	Access
Adolescent Well-Care Visits	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓

2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

The primary objective of the Child Medicaid CAHPS survey was to effectively and efficiently obtain information on the levels of parents'/caretakers' experience with the Hawaii child Medicaid members' 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 parents/caretakers of 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 CAHPS survey was accomplished through administration of the CAHPS 5.1H Child Medicaid Health Plan Survey (without the CCC measurement set) to parents/caretakers of child members of the QI health plans, and the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the CCC measurement set) to parents/caretakers of CHIP members. Parents/caretakers of child Medicaid and CHIP members included as eligible for the survey were 17 years of age or younger as of December 31, 2020. All parents/caretakers of sampled members completed the surveys from February to May 2021 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 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 CATI. It is important to note that the CAHPS 5.1H Child Medicaid Health Plan Survey is made available by NCQA in English and Spanish only.[A-4] Therefore, prior to the start of the CAHPS survey process, and in following NCQA HEDIS Specifications for Survey Measures, HSAG submitted a request for a survey protocol enhancement and received NCQA's approval to allow the parents/caretakers of child members the option to complete the CAHPS survey in the designated alternate languages.[A-5]

The 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 child Medicaid and CHIP members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. An analysis of the CAHPS 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

[A-4] Administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. NCQA's approval of this survey protocol enhancement was required in order to allow parents/caretakers of child members the option to complete the CAHPS survey questionnaire in these alternate languages.

[A-5] National Committee for Quality Assurance. *HEDIS® Measurement Year 2020, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2020.

should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

The survey questions were categorized into 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 2020 Quality Compass Benchmark and Compare Quality Data.[A-6] 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-12:

Table A-12—Star Ratings

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

[A-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020*. Washington, DC: NCQA, September 2020.

Additionally, HSAG performed a trend analysis of the child Medicaid and CHIP results. The child Medicaid 2021 scores were compared to their corresponding 2019 scores, and the CHIP 2021 scores were compared to their corresponding 2020 scores to determine whether there were statistically significant differences.[A-7] Statistically significant differences between the current year's top-box scores and the previous year's top-box scores are noted with directional triangles. Scores that were statistically significantly higher in the current year than the previous year are noted with black upward (▲) triangles. Scores that were statistically significantly lower in the current year than the previous year are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, HSAG performed plan comparisons of the child Medicaid results. Statistically significant differences between the QI health plans' top-box responses and the QI Program aggregate are noted with arrows. A QI health plan's top-box score that was statistically significantly higher than the QI Program aggregate is noted with an upward (↑) arrow. A QI health plan's top-box score that was statistically significantly lower than the QI Program aggregate is noted with a downward (↓) arrow. A QI health plan's top-box score that was not statistically significantly different than the QI Program aggregate is not denoted with an arrow.

Also, scores for the child Medicaid QI health plans, QI Program aggregate, and CHIP 2021 were compared to the 2020 NCQA child Medicaid national averages.[A-8] Scores that are at or above the 2020 NCQA child Medicaid national averages are represented by yellow highlighted cells. Scores that are below the 2020 NCQA child Medicaid national averages are represented by red highlighted cells. 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 child 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 parents'/caretakers' 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.

[A-7] The adult Medicaid population was last surveyed in 2020; therefore, the 2021 child Medicaid CAHPS scores are compared to the corresponding 2019 scores.

[A-8] NCQA national averages for the child Medicaid population were used for comparative purposes for the CHIP population since NCQA does not provide separate benchmarking data for this population. Therefore, caution should be exercised when interpreting these results.

Description of Data Obtained

The CAHPS survey asks parents/caretakers to report on and to evaluate their experiences with their child's healthcare. The survey covers important topics such as the communication skills of providers and the accessibility of services. The surveys were administered from February to May 2021. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the designated five questions were completed.[A-9] Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), or had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

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

The plan-specific results of the CAHPS survey are summarized in Section 3 and the CHIP results of the CAHPS survey are summarized in Section 1 of this report. A statewide comparison of each child Medicaid QI health plan and the QI Program aggregate results, as well as the CHIP population results, are provided in Section 4.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the health plans, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-13.

Table A-13—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
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	✓		

[A-9] A survey was assigned a disposition code of "completed" if at least three of the following five questions were completed for child Medicaid and CHIP: questions 3, 10, 22, 26, and 31.

Provider Survey

Objective

The objective of the Provider Survey was to provide feedback to the MQD and the health plans about providers' perceptions of the QI health plans.

Technical Methods of Data Collection and Analysis

The method of data collection was through the administration of the 2021 Hawaii Provider Survey to a random sample of 1,500 providers: 200 KFHP providers (i.e., KFHP QI) and 1,300 non-KFHP providers (i.e., AlohaCare QI, HMSA QI, 'Ohana QI, and UHC CP QI). Providers eligible for sampling included those who served the Hawaii Medicaid population, contracted with at least one of the QI health plans, and had the following credentials: doctor of medicine (MD), doctor of osteopathic medicine (DO), physician assistant (PA), psychologist, or advanced practice registered nurse (APRN). The survey administration consisted of mailing sampled providers a survey questionnaire, cover letter, and business reply envelope. Providers were given two options by which they could complete the surveys: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope; or (2) complete the web-based survey by logging on to the survey website with a designated, provider-specific login. The survey was administered from July to September 2021. The survey administered to KFHP providers included 15 questions, and the survey administered to non-KFHP providers included 17 questions on a broad range of topics.

The 2018 and 2021 Hawaii Provider Survey results for participating QI health plans were presented on the following six domains of satisfaction:

- **General Positions**—presents providers' level of satisfaction with the reimbursement rate (pay schedule) or compensation, and providers' level of satisfaction with the timeliness of claims payments.
- **Providing Quality Care**—presents providers' level of satisfaction with the QI health plans' prior authorization process and formulary, in terms of having an impact on providers' ability to deliver quality care.
- **Non-Formulary**—presents providers' level of satisfaction with access to nonformulary drugs.
- **Service Coordinators**—presents providers' level of satisfaction with the helpfulness of service coordinators.
- **Specialists**—presents providers' level of satisfaction with the QI health plans' number of specialists and availability of mental health providers, including psychiatrists.
- **Substance Abuse**—presents providers' level of satisfaction with the QI health plans' access to substance abuse treatment for patients.

- Response options to each question (i.e., measure) within these domains were classified into one of three response categories: satisfied, neutral, and dissatisfied; or positive impact, neutral impact, and negative impact. For each measure, the proportion (i.e., percentage) of responses in each of the response categories was calculated.[A-10] Health plan survey responses were not limited to those providers who indicated they were currently accepting new patients for that health plan in Question 1 of the survey. For example, if providers indicated that they were not currently accepting new patients for AlohaCare in Question 1, the response would be included in the results pertaining to AlohaCare if a response had been provided. Therefore, providers may have rated a health plan on a survey question even if they were not currently accepting new patients for that plan. Furthermore, a provider associated with more than one health plan may have answered a question for multiple health plans.

A Hierarchical Latent Variable Model was used to determine if statistically significant differences in performance existed between the QI health plans' top-box scores and the QI Program aggregate, and between the 2021 and corresponding 2018 top-box scores. As is standard in most survey implementations, a top-box score was defined by a positive or satisfied response.

Statistically significant differences between the QI health plans' top-box responses and the QI Program aggregate are noted with arrows. A QI health plan's top-box score that was statistically significantly higher than the QI Program aggregate is noted with an upward (↑) arrow. A QI health plan's top-box score that was statistically significantly lower than the QI Program aggregate is noted with a downward (↓) arrow. A QI health plan's top-box score that was not statistically significantly different than the QI Program aggregate is not denoted with an arrow.

Statistically significant differences between the 2021 top-box scores and the corresponding 2018 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in 2021 than in 2018 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2021 than in 2018 are noted with black downward (▼) triangles. Scores in 2021 that were not statistically significantly different from scores in 2018 are not noted with triangles.

Description of Data Obtained

The survey covered topics for primary care and specialty providers including the impact of plans' prior authorization procedures and formulary on the providers' ability to provide quality care. Additional survey questions elicited information about reimbursement satisfaction, adequacy of access to nonformulary drugs, service coordinators, adequacy of access to specialty providers, availability of mental health providers, and access to substance abuse treatment. The response rate was the total number of completed surveys divided by all eligible providers within the sample. Eligible providers included the entire sample minus ineligible providers, which included any providers who could not be

[A-10] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2021 Hawaii Provider Survey full report.

surveyed due to incorrect or incomplete contact information or who had no current contract with any of the QI health plans.

Following the administration of the provider survey, HSAG provided the MQD with an aggregate report of plan-specific findings. The plan-specific results are summarized in Section 3, and statewide comparisons of all plans' results are summarized in Section 4 of this report.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the health plans, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-14.

Table A-14—Assignment of Provider Survey Measures to the Quality, Timeliness, and Access Domains

Provider Survey Topic	Quality	Timeliness	Access
Compensation Satisfaction	NA	NA	NA
Timeliness of Claims Payments	NA	NA	NA
Formulary	✓		
Prior Authorization Process	✓	✓	
Adequate Access to Non-Formulary Drugs	✓		
Helpfulness of Service Coordinators	✓		
Adequate Network of Specialists			✓
Availability of Mental Health Providers			✓
Access to Substance Abuse Treatment			✓

NA indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).

Encounter Data Validation

Objective

Accurate and complete encounter data are critical to the success of any managed care program. In CY 2020, the MQD evaluated 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 focused 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 provided 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 was designed to seek an understanding of what reports the MQD currently receives and identify any potential modifications necessary to elevate their comprehensiveness in assessing data quality. Additionally, the gap analysis also reviewed 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 identified and presented 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 also synthesized 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 assessed 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

Description of Data Obtained

The administrative profile component of the CY 2020 encounter data validation study used numerous data sources including encounter data, member demographic/enrollment data, and provider data. Based on the study objectives and data elements 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 examined the accuracy, completeness, and timeliness of the MQD's encounter data with service dates between January 1, 2019, and December 31, 2019.

How Conclusions Were Drawn

The encounter data information systems assessment activities included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members. HSAG used the results from this assessment to document current health plan processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data. HSAG used a customized checklist to systemically identify areas for improvement or enhancement. From this analysis, HSAG provided actionable recommendations to the health plans based on the existing encounter data systems.

HSAG used data obtained from the MQD and the health plans to draw conclusions. Five encounter types (i.e., institutional, professional, pharmacy, LTC, and hospital outpatient) were examined for the degree of encounter data accuracy, completeness, and timeliness of encounter data submission. HSAG, in collaboration with the MQD, selected key fields that included date of service, payment date, member ID, billing and rendering provider ID, primary and secondary diagnosis codes, procedure code(s), revenue code(s), and national drug codes (NDCs). From these analyses, HSAG provided actionable recommendations to the health plans for improving encounter data completeness, accuracy, and timeliness of submission.