State of Hawaii

Department of Human Services

Med-QUEST Division

2022 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

April 2023

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary 1-1
Overview 1-1
Overall Summary of Health Plan Performance 1-4

2. Introduction 2-1
Purpose of the Report 2-1
Summary of Report Content 2-3
Overview of the Hawaii Medicaid Service Delivery System 2-4

3. Assessment of Health Plan Performance 3-1
Introduction 3-1
Methodology 3-1
AlohaCare QUEST Integration (AlohaCare QI) Results 3-2
Hawaii Medical Service Association QUEST Integration (HMSA QI) Results 3-27
Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results 3-50
'Ohana Health Plan QUEST Integration ('Ohana QI) Results 3-72
UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results 3-95
'Ohana Community Care Services ('Ohana CCS) Results 3-118

4. Comparative Analysis of Health Plan Performance 4-1
Introduction 4-1
Compliance Monitoring Review 4-1
Validation of Network Adequacy 4-2
Validation of Performance Measures—HEDIS Compliance Audits 4-13
Validation of Performance Improvement Projects 4-23
Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Adult Survey 4-24

5. Assessment of Follow-Up to Prior Year Recommendations 5-1
Introduction 5-1
Compliance Monitoring Review 5-1
Performance Improvement Projects 5-1
AlohaCare QUEST Integration (AlohaCare QI) 5-2
HMSA QUEST Integration (HMSA QI) 5-11
Kaiser Foundation Health Plan QUEST Integration (KFHP QI) 5-18
'Ohana Health Plan QUEST Integration ('Ohana QI) 5-25
UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) 5-33
'Ohana Community Care Services ('Ohana CCS) 5-42

Appendix A. Methodologies for Conducting EQR Activities A-1

1. Executive Summary

Overview

The 2022 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 in Hawaii. The QI health plans include five managed care organizations (MCOs) contracted with the MQD to provide physical health and behavioral health services to Medicaid members. The MQD also contracted with one prepaid inpatient health plan (PIHP), also known as Community Care Services (CCS), to provide behavioral health specialty services for individuals who have been determined by the MQD to have a serious mental illness (SMI). The MCOs and PIHP that contracted with the MQD during calendar year (CY) 2022 are displayed in Table 1-1.

Table 1-1—Medicaid Managed Care Health Plans in Hawaii

MCO Name	MCO Short Name
AlohaCare QUEST Integration	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
UnitedHealthcare Community Plan QUEST Integration	UHC CP QI
PIHP Name	**PIHP Short Name**
'Ohana Community Care Services	'Ohana CCS

[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.

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]

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 and optional activities for compliance with standards, network adequacy, performance measures, performance improvement projects (PIPs), and consumer satisfaction surveys.
- 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 evaluated the health plans' compliance with State and federal requirements for organizational and structural performance. The MQD contracts with the EQRO to conduct a review of one-half of the full set of standards in year 1 and year 2 to complete the cycle within a three-year period. HSAG conducted on-site compliance reviews in June 2022. The health plans submitted documentation that was in effect

[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: October 6, 2022.

July 1, 2021, through May 6, 2022. HSAG provided detailed, final audit reports to the health plans and the MQD in September 2022.

- *Network Adequacy Validation (NAV).* HSAG administered a Provider Data Structure Questionnaire (PDSQ) to all participating health plans in CY 2022 and conducted a review of the MQD's existing Provider Network Adequacy Verification (PNA) report and procedures. HSAG disseminated the MQD-approved PDSQ to all participating health plans and received questionnaire responses and supplemental documents from all participating health plans in September 2022.
- *Validation of performance measures*. HSAG validated each health plan's performance measure results for a set of Healthcare Effectiveness Data and Information Set (HEDIS)®[1-3] 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™[1-4] guidelines and timeline, which occurred from January 2022 through July 2022. The final audited performance measure validation results for each health plan reflected the measurement period of January 1, 2021, through December 31, 2021. HSAG provided final audit reports to the health plans and the MQD in July 2022.
- *Validation of performance improvement projects (PIPs).* HSAG validated PIPs to ensure that 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.[1-5] In CY 2022, the health plans submitted two new PIPs each and those were reviewed and validated by HSAG. HSAG also provided PIP trainings to the health plans prior to the PIP submissions, and additional technical assistance was provided to the health plans upon request throughout the year.
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys*.[1-6] The MQD conducted CAHPS surveys of the adult QI health plans and Children's Health Insurance Program (CHIP) populations to learn more about members' experiences with care. The standardized survey instrument administered to adult Medicaid members of the QI health plans and parents/caretakers of child members enrolled in CHIP was the CAHPS 5.1H Adult Medicaid Health Plan Survey and CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with chronic conditions [CCC] measurement set), respectively. All sampled members completed the surveys from February to May 2022. HSAG aggregated and produced final reports in September 2022.

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-4] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
[1-5] 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: Feb 24, 2023.
[1-6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Overall Summary of Health Plan Performance

Compliance Monitoring Review

CY 2022 began a new three-year cycle of compliance reviews for the QI health plans and the CCS program.

For the 2022 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the CFR for eight areas of review, or standards. Both a pre-on-site desk review and an on-site review with interview sessions, system and process demonstrations, and record reviews were conducted. The second compliance review activity in 2022 involved HSAG's and the MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to findings from the 2022 compliance review.

Findings, Conclusions, and Recommendations

Table 1-2 summarizes the results from the 2022 compliance monitoring reviews. This table contains high-level results used to compare the Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the eight compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

Table 1-2—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I. Availability of Services	100%	100%	94%	97%	100%	96%	**98%**
II. Assurances of Adequate Capacity and Services	100%	100%	50%	100%	100%	100%	**92%**
III. Coordination and Continuity of Care	90%	95%	95%	90%	100%	100%	**95%**
IV. Confidentiality	100%	100%	100%	100%	100%	100%	**100%**
V. Coverage and Authorization of Services	92%	98%	100%	89%	100%	93%	**95%**
VI. Enrollee Information	89%	89%	92%	84%	95%	86%	**89%**
VII. Enrollee Rights and Protections	94%	100%	94%	94%	94%	93%	**95%**
VIII. Grievance and Appeal System	97%	92%	98%	100%	98%	100%	**98%**
Totals	**95%**	**96%**	**96%**	**93%**	**98%**	**95%**	**96%**

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

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. One standard was found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—Confidentiality. Additionally, all but one health plan scored 100 percent in Assurances of Adequate Capacity and Services. The Enrollee Information and Enrollee Rights and Protections standards were identified as having the greatest opportunity for improvement with statewide compliance scores of 89 percent and 95 percent, respectively. No health plans achieved 100 percent in the Enrollee Information standard, and only one health plan was found to be fully compliant in the Enrollee Rights and Protections standard. Overall, three of the six health plans achieved a total compliance score at or above the statewide average.

Individual health plan performance revealed the following:

- AlohaCare QI's performance across all standards was average, meeting or exceeding the statewide compliance score for four of the eight standards.
  - AlohaCare QI had a total compliance score of 95 percent, with three of the eight standards scoring 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, and Confidentiality.
  - With four of the 19 elements found to be *Partially Met* and a compliance score of 89 percent, AlohaCare QI has the greatest room for improvement in the Enrollee Information standard.
  - AlohaCare QI was required to develop a corrective action plan (CAP) to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.
- HMSA QI's performance across all standards was above average, meeting or exceeding the statewide compliance score for seven of the eight standards.
  - HMSA QI had a total compliance score of 96 percent, with four of the eight standards scoring 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, Confidentiality, and Enrollee Rights and Protections. HMSA QI also achieved a high score (98 percent) in the Coverage and Authorization of Services standard, with only one element scoring *Partially Met*.
  - HMSA QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor HMSA's QI CAP activities until the health plan is found to be in full compliance.
- KFHP QI's performance across all standards was average, meeting or exceeding the statewide compliance score for five of the eight standards.
  - KFHP QI had a total compliance score of 96 percent, with two of the eight standards scoring 100 percent: Confidentiality and Coverage and Authorization of Services. Additionally, KFHP QI achieved high scores in the Coordination and Continuity of Care and the Grievance and Appeal System standards, with all elements in each standard found to be fully compliant except one.
  - With all three elements found to be *Partially Met* and a compliance score of 50 percent, KFHP QI has the greatest room for improvement in the Assurances of Adequate Capacity and Services standard.

  - KFHP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor KFHP's QI CAP activities until the health plan is found to be in full compliance.
- 'Ohana QI's performance across all standards was below average, meeting or exceeding the statewide compliance score for three of the eight standards.
  - 'Ohana QI had a total compliance score of 93 percent, with three of the eight standards scoring 100 percent: Assurances of Adequate Capacity and Services, Confidentiality, and Grievance and Appeal System.
  - 'Ohana QI scored below the statewide average for five of the eight standards, indicating that those standards have the greatest room for improvement.
  - 'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana QI's CAP activities until the health plan is found to be in full compliance.
- UHC CP QI's performance across all standards was above average, meeting or exceeding the statewide compliance score for seven of the eight standards.
  - UHC CP QI had the highest performance, with a total compliance score of 98 percent. Five of the eight standards scored 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, and Coverage and Authorization of Services. UHC CP QI also achieved a high score (98 percent) in the Grievance and Appeal System standard, with only one element scoring *Partially Met*.
  - UHC CP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor UHC CP's CAP activities until the health plan is found to be in full compliance.
- 'Ohana CCS' performance across all standards was average, meeting or exceeding the statewide compliance score for four of the eight standards.
  - 'Ohana CCS had a total compliance score of 95 percent, with four of the eight standards scoring 100 percent: Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, and Grievance and Appeal System.
  - With four elements requiring corrective actions in Coverage and Authorization of Services and Enrollee Information, these standards have the greatest room for improvement.
  - 'Ohana CCS was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

With the completion of compliance monitoring reviews and initiation of the corrective action process, the health plans and CCS have demonstrated their structural and operational compliance and ability to support the provision of quality, timely, and accessible services. CY 2023 will be the second year in the three-year cycle for compliance reviews. The reviews will target the remaining eight standards: Provider Selection, Credentialing, Subcontractual Relationships and Delegation, Enrollment and Disenrollment, Practice Guidelines, Program Integrity, Quality Assessment and Performance Improvement, and Health Information Systems.

Validation of Network Adequacy

During CY 2022, HSAG administered a PDSQ to all participating health plans and conducted a review of the MQD's existing PNA report and procedures.

Findings, Conclusions, and Recommendations

PNA methodology review findings: HSAG noted that the MQD has very thorough instructions for the plans regarding the completion of the quarterly provider network adequacy reports. The MQD provides detailed descriptions of the requested classification of providers, defining the rurality of providers, member populations, and the calculation of the travel distance metrics. Based on HSAG's review, the MQD's requirements are well documented for the health plans. HSAG identified suggestions for clarification that might assist the user while reviewing the Health Plan Manual—Reporting Guide, including additional clarification around some terminology or examples that might further explain concepts to the user.

PDSQ findings: HSAG distributed the MQD-approved PDSQ to each health plan to request qualitative responses for 10 questionnaire elements and to provide supplemental documentation supporting the responses (e.g., data dictionaries, data file layouts, or sample reports). All health plans participated in the questionnaire process and responded to HSAG's email requests for clarification, when needed. Each health plan's questionnaire responses were self-reported, and HSAG did not validate the responses against additional data sources. Notable findings across all health plans' questionnaire responses included the following:

- The health plans' questionnaire responses reflected a variety of operating platforms, claims payment systems, and systems for delegating management of selected services to outside entities (e.g., delegating vision services to a third-party vendor).
- Each health plan relied on its participating providers to self-report information such as provider type, provider specialty, taxonomy code(s), degree(s), and licenses and certifications. The health plans listed a variety of methods by which they confirm and validate the provider information (e.g., against external sources such as the National Plan and Provider Enumeration System [NPPES] and National Provider Identifier [NPI] Registry).
- All health plans reported maintaining data fields to readily identify primary care providers (PCPs), active/inactive providers, and telehealth providers.
- All health plans reported the use of single case agreements (SCAs) and/or letters of agreement (LOAs) to contract with nonparticipating providers.

Recommendations: Based on findings from the CY 2022 activities, HSAG offers the following recommendations for the MQD:

- HSAG noted that data submitted by the health plans for the PNA analysis did not completely align with the instructions in the PNA methodology. HSAG understands that the MQD is continuing to collaborate with the health plans on the quarterly data submission process and understanding of the

PNA instructions. HSAG recommends that the MQD continue this process to educate the health plans to ensure a seamless and efficient process in the future.

- The MQD could consider requesting documentation of the health plans' internal verification and oversight practices to ensure the accuracy of their provider data.
- The MQD could consider requesting copies of the health plans' policies, procedures, and recent reports for monitoring provider data received from vendors, including information demonstrating how frequently provider data anomalies are identified and corrected. The MQD's review of the health plans' documentation will allow the MQD to verify that each health plan is routinely validating vendor data and updating information found in the corresponding online provider directory. The MQD should work with each health plan to determine the appropriate frequency of vendors' data submissions, overall data reviews, and a timeline for subsequent investigations and data reconciliation.
- The MQD could consider requesting copies of the health plans' documentation reflecting the use and oversight of SCAs or LOAs to verify that the plans are not using SCAs or LOAs in lieu of providing robust networks of providers.
- HSAG recommends that the MQD continue to refine the PNA procedures and instructions manual with edits for clarity that may assist the user. Some examples include:
  - Additional clarification around the PCP classifications and the difference between PCP (Adult), PCP (Child), and Primary Care Providers.
  - Additional clarification around driving time calculations with telehealth providers and when telehealth providers may be used to fill gaps in health plans' ability to meet the network adequacy standards established by the MQD.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the *HEDIS Measurement Year (MY) 2021 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 2021 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' information system (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

[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.

health. The measurement period was CY 2021 (January 1, 2021, through December 31, 2021), and the audit activities were conducted concurrently with HEDIS MY 2021 reporting.

For MY 2021 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;* 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; CMS' Measures for Medicaid Long Term Services and Supports Plans, Technical Specifications and Resource Manual, May 2019,* and NCQA's *HEDIS Measurement Year 2021 & Measurement Year 2022, Technical Specifications for Long-Term Services and Supports Measures.* 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 17 measures, yielding a total of 74 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 six 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
- Long-Term Services and Supports (LTSS)

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 2021 NCQA HEDIS Compliance Audits. HSAG determined all QI health plans and the CCS program to be *fully compliant* with all NCQA HEDIS IS standards. 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 2021 performance measure results for each health plan, and where applicable, HSAG compared the results to NCQA's Quality Compass®, [1-9] national Medicaid health

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

maintenance organization (HMO) percentiles for HEDIS MY 2020 (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—Hemoglobin A1c (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]

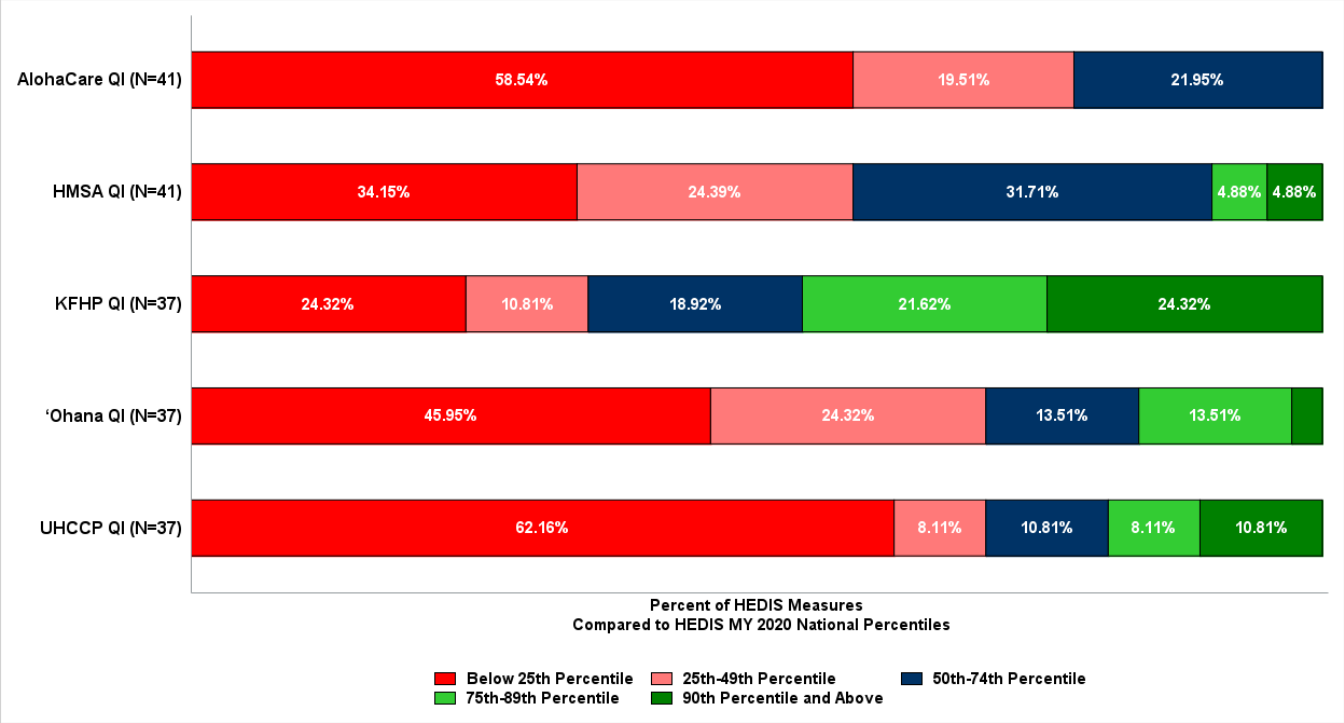
Additionally, HSAG analyzed the results for one performance measure developed by the MQD (i.e., *Behavioral Health Assessment*), two CMS *Adult Core Set* measures, one CMS *Child Core Set* measure, two NCQA LTSS measures, and one CMS LTSS measure. Of note, these measures do not have applicable benchmarks 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 2021 performance compared to benchmarks, where applicable. HSAG analyzed results from 17 performance measures for HEDIS MY 2021 (a total of 74 indicator rates), of which 41 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).

[1-10] 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

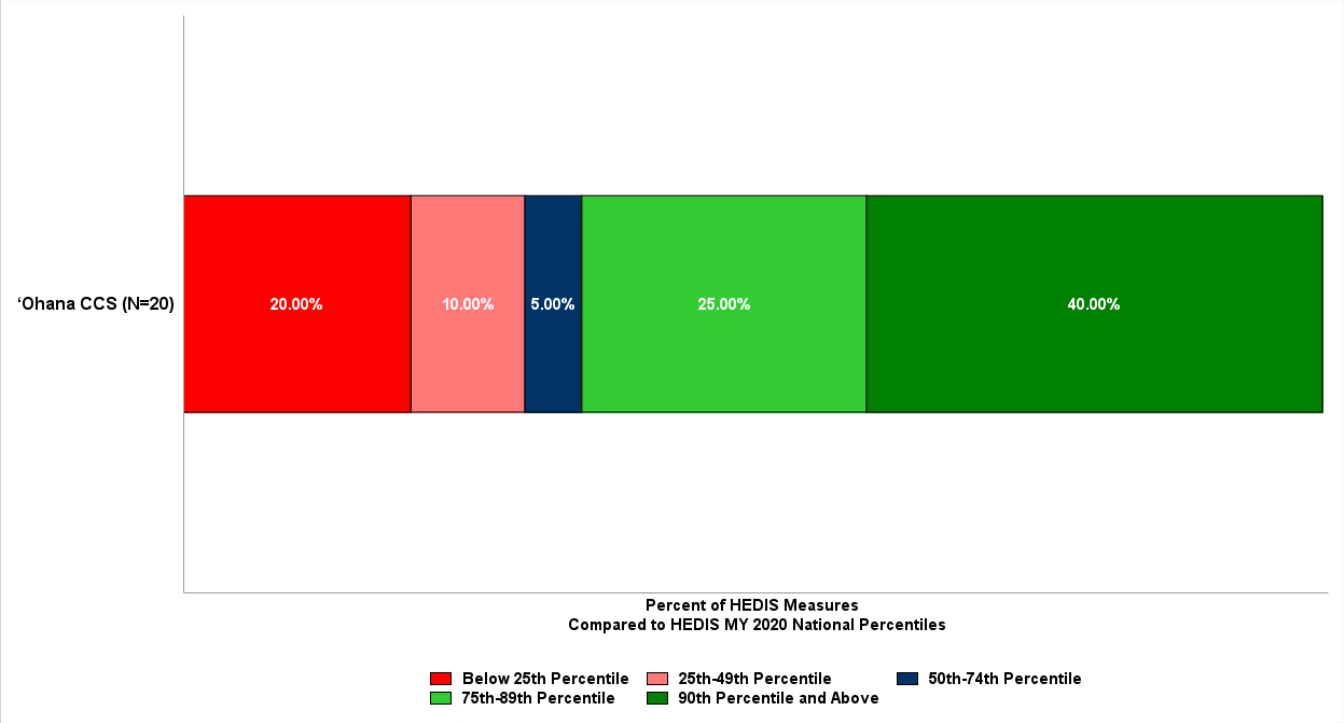


As presented in Figure 1-1, KFHP QI was the highest-performing plan for HEDIS MY 2021, with 24 of 37 (64.9 percent) measure rates ranking at or above the 50th percentile, including eight rates (21.6 percent) meeting or exceeding the 75th percentile and nine rates (24.3 percent) meeting or exceeding the 90th percentile. HMSA QI was the second highest performing health plan, with 16 of 41 (39.0 percent) measure rates ranking at or above the 50th percentile, including two rates (4.9 percent) ranking at or above the 75th percentile and two rates (4.9 percent) ranking at or above the 90th percentile. For 'Ohana QI, 11 of 37 (29.7 percent) measure rates met or exceeded the 50th percentile, with four measure rates (10.8 percent) meeting or exceeding the 75th percentile and one measure rate (2.7 percent) ranking at or above the 90th percentile.

Conversely, 32 of AlohaCare QI's 41 (78.1 percent) measure rates, 24 of HMSA QI's 41 (58.5 percent) measure rates, and 13 of KFHP QI's 37 (35.1 percent) measure rates fell below the 50th percentile, while UHC CP QI and 'Ohana QI fell below the 50th percentile for 26 of 37 (70.3 percent) measure rates, respectively, indicating opportunities for improvement. Further, 24 of AlohaCare QI's 41 measure rates (58.5 percent), 14 of HMSA QI's 41 measure rates (34.2 percent), nine of KFHP QI's 37 measure rates (24.3 percent), 17 of 'Ohana QI's 37 measure rates (46.0 percent), and 23 of UHC CP QI's 37 measure rates (62.2 percent) fell below the 25th percentile.

Figure 1-2 displays 'Ohana CCS' HEDIS MY 2021 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. Three of the 14 measure rates (15.0 percent) ranked at or above the 75th percentile but below the 90th percentile, and eight of the 14 measure rates (40.0 percent) met or exceeded the 90th percentile. Conversely, four of 20 (20.0 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 2021.

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 CY 2022, HSAG validated two PIPs for each of the five QUEST Integration health plans and one PIHP—'Ohana CCS. The PIP topics for all the QI plans were *Behavioral Health Coordination* and *Plan All-Cause Readmissions*. The PIP topics for 'Ohana CCS were *Behavioral Health Coordination* and *Follow–Up After Emergency Department Visit for Mental Illness*. The PIPs addressed CMS' requirements related to quality outcomes—specifically, access to and timeliness of care and services.

Findings, Conclusions, and Recommendations

For the CY 2022 submission, the health plans progressed to the Design and Implementation stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form.

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

- All five QI health plans received an overall *Met* status for both the PIPs.
- 'Ohana CCS received an overall *Met* status for both the PIPs.

Table 1-3 summarizes HSAG's key validation findings for the two PIPs conducted by the QI health plans

Table 1-3—PIP Validation Findings for the QI Health Plans

Health Plan	*Behavioral Health Coordination*			*Plan All-Cause Readmissions*		
	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
AlohaCare QI	100%	100%	*Met*	100%	100%	*Met*
HMSA QI	100%	100%	*Met*	93%	100%	*Met*
KFHP QI	100%	100%	*Met*	100%	100%	*Met*
'Ohana QI	93%	100%	*Met*	93%	100%	*Met*
UHC CP QI	100%	100%	*Met*	100%	100%	*Met*

Table 1-4 summarizes HSAG's key validation findings for the two PIPs conducted by 'Ohana CCS.

Table 1-4—PIP Validation Findings for 'Ohana CCS

Health Plan	*Behavioral Health Coordination*			*Follow–Up After Emergency Department Visit for Mental Illness*		
	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
'Ohana CCS	93%	100%	*Met*	100%	100%	*Met*

Based on the PIPs validations, HSAG has the following recommendations:

- The health plans should continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP:
  - The health plans should document their progress toward implementing the interventions.

  - The baseline data for the performance indicators should be updated as the health plans determine the information sharing and data collection processes for all the trigger events and with all the partnering agencies.
  - Even though the PIP measurement periods are based on the third quarter in a calendar year, the health plans should collect the performance indicators' data on a quarterly basis and report quarterly data in Step 7 of the PIP Submission Form.
  - The health plans should capture the informal combined reviews based on the systems/data that they have and document how they are defining and capturing these data. The health plans should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The health plans should update Step 3 and Step 5 of the PIP Submission Form with any changes made to the performance indicator specifications; for example, the combined review trigger events that were approved by the MQD should be updated in the next annual submission.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plans should document the barriers, interventions, and QI activities undertaken as part of the Readmissions Collaborative workgroup to improve the HEDIS *Plan All-Cause Readmissions* (*PCR)* measure rate.
- The health plans should continue to conduct the causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions. The health plans should consider using science-based quality improvement tools, such as process mapping and failure modes and effects analyses (FMEA) for barrier analysis.
- The health plans should have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- The health plans must address HSAG's feedback in the PIP Validation Tools in the next annual submission.
- The health plans should seek technical assistance from HSAG and the MQD throughout the PIP process to address any questions or concerns.

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

The CAHPS health plan surveys are standardized survey instruments which measure patients' experience with their healthcare. For 2022, HSAG administered the CAHPS 5.1H Adult Medicaid Health Plan Survey to adult Medicaid members of the QI health plans and the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set to a statewide sample of CHIP members who met age and enrollment criteria. All sampled adult Medicaid members and parents/caretakers of sampled CHIP members completed the surveys from February to May 2022 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 applying this scoring methodology, the proportion (i.e., percentage) of top-box responses was calculated in order to determine the top-box scores.

Findings, Conclusions, and Recommendations

Table 1-5 presents the 2022 percentage of top-box responses (i.e., top-box scores) for the QI Program aggregate compared to the 2021 NCQA adult Medicaid national averages and the corresponding 2020 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 2021 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-14]

Table 1-5—QI Program Adult CAHPS Results

Measure	2020 Scores	2022 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	64.3%	61.6%	★★
Rating of All Health Care	57.7%	58.4%	★★★
Rating of Personal Doctor	69.4%	65.1% ▼	★
Rating of Specialist Seen Most Often	69.2%	70.1%	★★★
Composite Measures			
Getting Needed Care	80.3%	79.2%	★
Getting Care Quickly	79.0%	75.8%	★

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

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

[1-13] The adult population was last surveyed in 2020; therefore, the 2022 adult CAHPS scores are compared to the corresponding 2020 scores.

[1-14] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

Measure	2020 Scores	2022 Scores	Star Ratings
How Well Doctors Communicate	94.0%	90.6% ▼	★
Customer Service	87.3%	84.7%	★
Individual Item Measure			
Coordination of Care	88.2%	81.7% ▼	★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2021 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2021 NCQA adult Medicaid national averages.
▲ Indicates the 2022 score is statistically significantly higher than the 2020 score.
▼ Indicates the 2022 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

Comparison of the QI Program aggregate's 2022 scores to the 2021 NCQA adult Medicaid national averages revealed the following summary results:

- The QI Program aggregate's scores were not statistically significantly higher than the national averages for any of the measures.
- The QI Program aggregate's scores were statistically significantly lower than the national averages on five measures: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Coordination of Care*.

Comparison of the QI Program aggregate's 2022 scores to the corresponding 2020 scores revealed the following summary results:

- The 2022 QI Program aggregate's scores were not statistically significantly higher than the 2020 scores on any measures.
- The 2022 QI Program's scores were statistically significantly lower than the 2020 scores on three measures: *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care*.

Comparison of the QI Program's 2022 scores to the 2021 NCQA adult Medicaid Quality Compass data revealed the following:

- The QI Program aggregate did not score at or above the 90th percentile on any measures.
- The QI Program aggregate scored below the 25th percentile on six measures: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.

Table 1-6 presents the 2022 percentage of top-box responses (i.e., top-box scores) for the Hawaii CHIP population compared to the 2021 NCQA child Medicaid national averages and the corresponding 2021 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 2021 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-15]

Table 1-6—CHIP CAHPS Results

	2021 Scores	2022 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	78.2%	72.3% ▼	★★
Rating of All Health Care	74.5%	68.9%	★
Rating of Personal Doctor	77.7%	79.5%	★★★
Rating of Specialist Seen Most Often	75.3%+	71.8%+	★★
Composite Measures			
Getting Needed Care	87.2%	80.8%	★
Getting Care Quickly	82.8%	83.1%	★
How Well Doctors Communicate	97.2%	94.4% ▼	★★★
Customer Service	82.9%+	90.0%+	★★★
Individual Item Measure			
Coordination of Care	90.4%	92.6%+	★★★★★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2021 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2021 NCQA child Medicaid national averages.
▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Comparison of the CHIP population's 2022 scores to the 2021 NCQA child Medicaid national averages revealed the following summary results:

- The CHIP population's scores were statistically significantly higher than the national averages on one measure: *Coordination of Care*.
- The CHIP population's scores were not statistically significantly lower than the national averages on any measures.

Comparison of the CHIP population's 2022 scores to the corresponding 2021 scores revealed the following summary results:

- The CHIP population's 2022 scores were not statistically significantly higher than the 2021 scores on any measures.

[1-15] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

- The CHIP population's 2022 scores were statistically significantly lower than the 2021 scores on two measures: *Rating of Health Plan* and *How Well Doctors Communicate*.

Comparison of the CHIP population's 2022 scores to the 2021 NCQA child Medicaid Quality Compass data revealed the following:

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

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.

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.

Network Adequacy Validation

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CMS rule 438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. HSAG collaborated with the MQD to modify and finalize existing NAV methodologies upon release of the CMS EQR protocol. However, the NAV activities conducted by HSAG in collaboration with the MQD for CY 2022 align with current federal regulations and will help prepare the MQD to meet the NAV requirements once the provisions go into effect.

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 Surveys

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

Technical Assistance

At the state's direction, the EQRO may provide technical guidance to groups of MCOs, PIHPs, PAHPs, or PCCM entities 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, 2022, through December 31, 2022, this report provides:

- A description of Hawaii's Medicaid service delivery system.
- A description of the 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 four federally mandated activities, one optional activity, and the technical assistance provided to MQD as set forth in 42 CFR §438.358:
  - Mandatory activities:
    - Compliance monitoring reviews
    - Network adequacy validation
    - Validation of performance measures
    - Validation of PIPs
  - Optional activities:
    - Administration of consumer surveys
    - Technical assistance
- A description of the methodologies used to conduct EQR activities included as an appendix.

Overview of the Hawaii Medicaid Service Delivery System

The Hawaii Medicaid Program

Medicaid covers more than 450,000[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 March 2022, as cited in *Hawaii Medicaid Enrollment Report (2021).* Available at: https://medquest.hawaii.gov/en/resources/reports.html. Accessed on: June 15, 2022.
[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: June 15, 2022.

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.

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 49,000 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: Feb 24 10, 2023.

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, validation of network adequacy, PMV and HEDIS audits, validation of performance improvement projects, adult 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 P4P incentive program. In CY 2022, with technical assistance provided by HSAG, the MQD implemented a multi-year P4P methodology in alignment with its Quality Strategy and the QI managed care populations.
- The MQD and HSAG continued to work with the health plans in annual PIP submission processes to facilitate more efficient and long-term sustained improvement. In CY 2022, the MQD contracted with HSAG to facilitate collaborative workgroups related to the two PIP topics: *Behavioral Health Coordination* and *Plan All-Cause Readmissions.* HSAG assisted the health plans with the creation of workgroup charters, provided training on quality improvement strategies, facilitated meetings, and provided ongoing support as the health plans completed quality improvement activities.

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 2022, 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

- Encourage health plans to implement innovative approaches to promote adult preventive care and pediatric well-child visits.
- 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.

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 (SUDs).

Recommendations

- Identify barriers (real or perceived) that inhibit members from seeking SUD treatment and implement solutions at the State and health plan level.
- Continue to encourage information sharing, collaboration, and care coordination among QI health plans, the CCS program, and State agencies that provide services to Medicaid members.
- Consider implementing incentive programs to encourage advanced practice registered nurses and PCPs to obtain advanced mental health training or certifications.

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

- Continue efforts to implement community integration and transition services for members with complex health needs and housing insecurity.

- Encourage communication and collaboration among health plans, providers, and State agencies in coordinating care among beneficiaries with high-need, high-cost conditions.

Goal 4: Support community initiatives to improve population health

Objectives

- Assess and address social determinants of health (SDoH) needs.

Recommendations

- Consider rewarding or recognizing creative care coordination programs/initiatives that strive to ensure members receive timely assessments and healthcare services that prevent and treat identified conditions, assess and refer members to appropriate community partners to address SDoH, and connect members to timely care and services.
- Encourage the health plans to invest in community health through community-based partnerships by supporting proven interventions that address SDoH and healthy lifestyles that improve population health.
- Ensure that health plan information systems can collect, store, and analyze SDoH data to support population health management, care coordination, and improved quality measurement and outcomes.

Goal 5: Enhance care in LTSS settings

Objectives

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

Recommendations

- Identify and implement solutions to barriers that impact reintegration of LTSS beneficiaries. For example, to address workforce shortages, the MQD could consider increasing payments or incentives to direct care workers providing HCBS services in an effort to recruit and retain them.
- Increase education to beneficiaries and family members about HCBS options to promote informed choice.
- Encourage health plans to implement policies that reduce barriers for hospital discharge planners to obtain approval for HCBS and ensure HCBS providers are available to deliver services immediately upon discharge.

Goal 6: Maintain access to appropriate care

Objectives

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

Recommendations

- Critically evaluate and refine network adequacy reporting and oversight, and enhance Hawaii-specific minimum network requirements to reflect the State's unique geography.
- Work with the health plans to develop a plan to address network gaps, particularly in rural and neighbor island communities, that considers increased payments or incentives to providers that travel to the neighbor islands to provide services, single case agreements for needed care, and telehealth services.

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

- Encourage the health plans to evaluate their payment structures to providers and increase payments to providers that improve health outcomes for members experiencing social risk factors.
- Consider developing and implementing an incentive measure program specifically for the CCS program to improve the quality and value of care provided to its SMI/serious and persistent mental illness (SPMI) members.

3. Assessment of Health Plan Performance

Introduction

This section of the report describes the results of HSAG's 2022 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. 2022 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 2022 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 2022 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

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

[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	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Availability of Services	17	17	17	0	0	0	100%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	0	100%
III	Coordination and Continuity of Care	10	10	8	2	0	0	90%
IV	Confidentiality	9	9	9	0	0	0	100%
V	Coverage and Authorization of Services	31	31	27	3	1	0	92%
VI	Enrollee Information	19	19	15	4	0	0	89%
VII	Enrollee Rights and Protections	8	8	7	1	0	0	94%
VIII	Grievance and Appeal System	31	31	29	2	0	0	97%
	Totals	**128**	**128**	**115**	**12**	**1**	**0**	**95%**

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

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

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

Strengths

AlohaCare QI was found to be 100 percent compliant with the Availability of Services and Assurances of Adequate Capacity of Services standards. AlohaCare QI had policies and procedures in place to monitor its network and ensure that all covered services were available and accessible to its members in a timely manner and met the standards developed by the State for network adequacy. Services included in the contract were made available to members 24 hours a day, seven days a week, when medically necessary. AlohaCare QI conducted ongoing monitoring of its network, which included the review of quarterly GeoAccess reports, results of member and provider experience surveys, and a review of out-of-network utilization.

The health plan was also fully compliant with the Confidentiality standard. AlohaCare QI maintained comprehensive policies and procedures that addressed all aspects related to the use and disclosure of protected health information (PHI) and personally identifiable information (PII). All newly hired staff members are required to receive privacy and security training at the time of hire and on an annual basis. AlohaCare QI had monitoring mechanisms that ensured that PHI and PII were safeguarded and released only with a member's authorization and in alignment with applicable federal regulations.

The health plan also scored high with the Grievance and Appeal System standard with 97 percent compliance, with only two of the 31 elements scoring *Partially Met.* AlohaCare QI maintained policies,

procedures, and systems for logging, tracking, and reporting member grievances and appeals. The health plan had several coordinators dedicated to the processing of grievances and appeals. A review of grievance and appeal files found that all cases were acknowledged and resolved within the required time frames and notifications to members were written in a manner and format that was easily understandable.

AlohaCare QI was found to be 94 percent compliant with the Enrollee Rights and Protections standard, with only one element scoring *Partially Met*. The health plan maintained policies, procedures, and written member and provider information regarding member rights. The health plan ensured the protection of member rights through in-service trainings, conducting provider visits, and member rights information on the provider portal. AlohaCare QI ensured that member-facing staff members are trained on protecting and upholding member rights annually and on an ad hoc basis. AlohaCare QI monitored grievances and appeals through quarterly reports to ensure that member rights were protected.

Finally, AlohaCare QI showed high compliance in the Coverage and Authorization of Services standard with 92 percent. AlohaCare QI's policies and procedures met the requirements for providing emergency, urgent, and poststabilization services; for ensuring consistent application of utilization management (UM) criteria (by conducting interrater reliability reviews); and for providing the required covered array of Medicaid services. AlohaCare QI provided evidence that it had the appropriate mechanisms in place for receiving, reviewing, processing, and monitoring service authorization decisions for members and providers. A review of service denials demonstrated that the files were well organized and provided evidence that AlohaCare QI monitored its UM processes to ensure timeliness and consistency of authorization decisions. All decisions were made within the required time frames and by providers with the appropriate clinical expertise. The notices of adverse benefit determination (NABDs) were written in a manner that was easily understood, at or below a sixth-grade reading level, and sent to the member and requesting provider.

Areas for Improvement

AlohaCare QI was found to be 90 percent compliant with the Coordination and Continuity of Care standard, with two of the 10 elements scoring *Partially Met.* AlohaCare QI had comprehensive policies, procedures, and processes in place to deliver and coordinate the care of its members. Documentation submitted by AlohaCare QI described the processes the health plan used to assess each member for any special health care needs (SHCN), enroll members in health coordination services, complete the comprehensive health and functional assessment (HFA), develop a person-centered health action plan (HAP) in conjunction with the member and involved providers, and provide ongoing support and health coordination activities. While policies and procedures identified the correct timeline for completing the HFA after referral to health coordination services, upon review of care coordination files, seven of the 10 files reviewed did not have a completed HFA within 15 days of SHCN identification. Documentation in the files indicated that AlohaCare QI was not making the initial outreach attempt to the member for several days to several weeks after SHCN identification. Additionally, two of the 10 files did not have evidence of the HAP being shared with the member's PCP or other involved providers. The corrective actions required by AlohaCare QI were to implement procedures to ensure that HFAs were completed

within the required time frame and that HAPs were being sent to the member's PCP or other involved providers.

AlohaCare QI was found to be 89 percent compliant with the Enrollee Information standard, with four elements scoring *Partially Met.* In general, AlohaCare QI had member information, customer service staff members, and service coordinators available to help members understand the requirements and benefits of the plan. The corrective actions required by AlohaCare QI were related to updates needed to the member portal, updates to policies and procedures in the event of a provider termination, updates to the member handbook to ensure it included information about the specific locations for emergency settings, and updates to the provider directory to include specific details regarding providers' office accommodations for people with physical disabilities.

Validation of Network Adequacy

Findings

Provider data structure: AlohaCare QI reported using the Cognizant TriZetto (QNXT) operating platform to store and access provider data. Additionally, AlohaCare QI's claims data were stored within the QNXT system and linked to both billing and rendering providers using specific identifiers, such as NPI and Taxpayer Identification Number (TIN). AlohaCare QI provided a file layout supporting its data structure descriptions, as requested.

Delegated services: AlohaCare QI reported delegating some services (i.e., contracting all or part of the provision of selected services, such as behavioral health [BH] services) to another entity. Table 3-2 summarizes AlohaCare QI's delegated provider type/services, delegated entity names, and the frequency with which the health plan received provider data from the delegated entity at the time of the questionnaire response.

Table 3-2—AlohaCare QI Delegated Services

Provider Type/Service	Delegated Entity Name	Provider Data Frequency
Non-emergency transportation services	IntelliRide	Provider data/rosters are shared monthly and as needed to maintain AlohaCare QI's provider data using a custom data layout. Includes both new providers and recent terminations.
Pharmacy benefit manager (PBM)	IngenioRx	Provider data/rosters are shared monthly and as needed to maintain AlohaCare QI's provider data using a custom data layout. Includes both new providers and recent terminations.
Online behavioral health/telehealth services	Amwell	Provider data/rosters are shared monthly and as needed to maintain AlohaCare QI's provider data using a custom data layout. Includes both new providers and recent terminations.

Regarding oversight of all delegated services, AlohaCare QI reported developing and executing formal subcontractor audits and monitoring to address regulatory and contractual obligations on an annual basis. As part of AlohaCare QI's reported delegation oversight process, as documented in the health plan's established delegation policies and procedures, AlohaCare QI conducted pre-delegation, periodic, and ongoing monitoring and auditing of all subcontractors. AlohaCare QI's oversight protocols for subcontractors included but were not limited to training and education, data validation and reporting, and payment integrity.

On an ongoing basis, AlohaCare QI's delegation oversight staff within operational units and AlohaCare QI's Compliance department performed monthly monitoring of subcontractors, including reviews of reports, metrics, and data to identify potential noncompliance or outlier activity and issue corrective actions, as appropriate. Reports of these monitoring activities were presented to AlohaCare QI's Delegated Vendor Oversight Committee (DVOC), which is a subcommittee of the Compliance Committee and also reports to the Board Compliance Committee of the Board of Directors. To ensure alignment with AlohaCare QI's delegated subcontractors' provider networks, delegated entities were contractually required to submit monthly rosters of network providers who provide services to AlohaCare QI members. AlohaCare QI used these monthly rosters to confirm and validate network participation and adequacy. Grievance and appeals data were monitored to identify issues relating to the performance of delegated entities. Resolutions to mitigate issues included closely working with the delegated entity to establish escalation steps, if needed; tasks; and timetables to ensure the implementation of timely and workable solutions. Findings from auditing and monitoring activities were subject to corrective actions including, but not limited to, disciplinary actions, suspension, termination, and recovery of overpayments or inappropriately billed amounts.

Provider classification data collection and maintenance: AlohaCare QI submitted information on selected provider categorization fields and supplied a corresponding data dictionary, as requested. Table 3-3 details all provider classifications in use by AlohaCare QI, as well as the mechanism for reporting and frequency of updating these classifications.

Table 3-3—AlohaCare QI Provider Classifications

Provider Classification	Reporting Mechanism	Update Frequency
Provider Type	Providers self-reported provider type information on enrollment/credentialing application.	Providers were required to update when changes occur and confirm information during recredentialing cycle.
Provider Specialty	Providers self-reported provider specialty information on enrollment/credentialing application.	Providers were required to update when changes occur and confirm information during recredentialing cycle.
Provider Taxonomy	Providers self-reported provider taxonomy information on enrollment/credentialing application.	Providers were required to update when changes occur and confirm information during recredentialing cycle.

Provider Classification	Reporting Mechanism	Update Frequency
Degree Attained (e.g., MD, RN, etc.)	Providers self-reported degrees attained information on enrollment/credentialing application.	Providers were required to update when changes occur and confirm information during recredentialing cycle.
Licenses and Certifications for Individuals and/or Facilities	Providers self-reported licenses and certifications on enrollment/credentialing application.	Providers were required to update when changes occur and confirm information during recredentialing cycle.
Network Participation	Based on contract status	As needed, based on contract status
PCP Flag	Providers self-reported	As needed
Credentialing Status	Based on provider's credentialing status	Recredentialing every 36 months
Other:	Providers self-reported	As needed

Provider indicators: HSAG asked each health plan to specify whether its provider data system included fields for the following provider indicators: PCP, Prenatal Care Providers, BH Providers, HCBS Providers, Active/Inactive Providers, Telehealth Providers, and SUD Providers, including those offering medication-assisted treatment (MAT). Table 3-4 details AlohaCare QI's reported responses and additional information regarding provider indicators.

Table 3-4—AlohaCare QI Provider Indicators

Provider Indicators	In Data System?	If Yes, Methods for Classifying Providers
PCPs	Yes	Providers with a provider specialty of Family Practice, General Practice, Advanced Practice Registered Nurse (APRN), Obstetrician and Gynecologist (OB/GYN), Internal Medicine, Geriatrics, or Pediatrics are generally set up with the PCP indicator set to "Yes." This includes clinics that provide primary care services. Other providers may elect to be a PCP if contractual requirements are met. AlohaCare QI's core system has a field indicating if provider is a PCP (Yes/No).
Prenatal Care Providers	No	N/A
Behavioral Health Providers	No	While not a specific indicator in the core system, these providers usually have a provider type of APRN, Autism Provider, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Mental Health Counselor, or Psychology. Providers with a specialty such as Addiction Medicine, Neuropsychology, Pediatric-Psychiatry, Psychiatry, or Psychiatry and Neurology are also considered BH providers.

Provider Indicators	In Data System?	If Yes, Methods for Classifying Providers
SUD Treatment Providers, including providers offering MAT	No	While not a specific indicator in the core system, these providers usually have a provider type of "Residential Treatment Facilities."
HCBS Providers	No	While not a specific indicator in core system, provider types such as Adult Day Care, Adult Day Health, Adult Foster Care, Adult Residential Care Home, Assisted Living, Case Management, Home Care Nursing, Home Delivered Meals, Home Health, Personal Care, and Personal Emergency Response are considered HCBS providers.
Active/Inactive Providers	Yes	Based on providers record status in AlohaCare QI's core system.
Telehealth Providers	Yes	Telehealth attributes in QNXT (other providers that render telehealth services can be identified through claims utilization).

Providers accepting new patients: AlohaCare QI confirmed that its provider data system included fields to identify providers accepting new patients for all participating providers and reported using each provider's self-reported information regarding whether the provider is accepting new patients.

Panel capacity: AlohaCare QI confirmed that its provider data system included fields to identify a provider's panel capacity. AlohaCare QI only maintained data related to panel capacity for PCPs, which included both new and existing patients, and was self-reported by each PCP.

Use of single case agreements: AlohaCare QI reported using LOAs with noncontracted providers willing to see AlohaCare QI members, based on medical necessity, and who requested custom reimbursement terms. These noncontracted providers were comprised of in- and out-of-state providers, and LOA provider rates were negotiated and agreed upon by both parties. The reimbursement terms were indicated in the LOA, were issued per individual member, and were in accordance with the prior authorized services, including the approved dates for the services. Service periods for LOA providers ranged from a single date of service, inpatient stay, to a span of multiple service dates based on the patient's needs.

For tracking purposes, these noncontracted providers with an LOA in place were linked to nonparticipating provider reimbursements in AlohaCare QI's core QNXT system. The member's prior authorizations were also maintained in the QNXT core system, with some claims pending in the claims processing system to allow LOA reimbursement terms to be manually processed by claims staff members. AlohaCare QI also had an internal tracking tool to manage all LOA requests and related activities.

Provider network monitoring: AlohaCare QI's reported network adequacy monitoring activities included, but were not limited to, various data reports (e.g., quarterly network adequacy GeoAccess reports), field intelligence (i.e., provider conferences), and internal intelligence and collaboration.

AlohaCare QI worked with providers to arrange care on-island. If the necessary care was not available from a network provider on island, then AlohaCare QI worked with nonparticipating providers to render the needed service. If an appropriate provider was not available on the member's island, AlohaCare QI arranged to bring the member to Oahu or out of state, as appropriate. These services were preauthorized and arranged by AlohaCare QI.

AlohaCare QI also looked for other initiatives to improve timely access to care. For example, AlohaCare QI had deployed solutions such as the coverage of e-consult services and expanded telehealth services to help address workforce shortages and improve timely access to care for members.

Health plans' provider data verification and cleaning: AlohaCare QI reported multiple strategies for verifying and cleaning provider data in accordance with NCQA requirements, including, but not limited to, utilizing standards credentialing and recredentialing forms and the IntelliCred and ProView software systems.

Communicating provider network information to members: AlohaCare QI reported that its members were informed of its participating provider network through multiple methods, including, but not limited to, AlohaCare QI's New Enrollee packet, welcome calls, and the Provider Finder tool on AlohaCare QI's website.

AlohaCare QI also contracted with providers via a delegated agreement. These contracting arrangements included participating pharmacies contracted under AlohaCare QI's PBM, transportation providers via IntelliRide that members scheduled by calling AlohaCare QI's Enrollee Services, and telehealth providers through AlohaCare QI's Telehealth Connect via Amwell. These providers were not included in the AlohaCare QI online provider directory network. In these situations, AlohaCare QI provided a direct link to the delegated provider network listing on the AlohaCare QI website.

Strengths

AlohaCare QI maintained detailed data regarding provider classifications (e.g., provider type, specialty, network participation, etc.), and reported multiple methods for updating, verifying, and cleaning provider data. AlohaCare QI also used multiple methods for monitoring its provider network and communicating provider network information to members.

Areas for Improvement

AlohaCare QI did not maintain data fields to identify prenatal care providers, BH providers, SUD treatment providers, or HCBS providers, although AlohaCare QI provided additional information regarding alternative methods of identifying these providers (e.g., HCBS providers did not have a specific indicator, but were identified by provider types such as Adult Day Care, Adult Foster Care, Home Delivered Meals, etc.)

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 two nonstandard data sources to review for MY 2021 reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2021 performance measure reporting.

AlohaCare QI was required to undergo convenience sample validation for the *Controlling High Blood Pressure* and *Cervical Cancer Screening* measures. All cases successfully passed the validation process. The final statistical medical record review validation (MRRV) was conducted for the *Controlling High Blood Pressure, Cervical Cancer Screening, Prenatal and Postpartum Care—Postpartum Care, Childhood Immunization Status—Combination 7,* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicators, and all medical record exclusions. All selected cases passed the final MRRV without any critical errors.

All 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 65 years and older stratification; AlohaCare QI followed the required specifications, but the denominators were 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 3-5. The *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* met or exceeded the 50th 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 (*Heart Failure Admission Rate—Total*), and AlohaCare QI met the target for HEDIS MY 2021.

Table 3-5—AlohaCare QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Heart Failure Admission Rate*				
18-64 Years	42.95	41.87	-2.51%	NC

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
65+ Years	147.04	138.55	-5.77%	NC
Total	53.26	50.84	-4.54%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	8.46%	8.90%	5.20%	★★★
Expected Readmissions—Total	10.14%	9.95%	-1.87%	NC
*Index Total Stays—Observed/Expected (O/E) Ratio—Total**	0.83	0.89	7.78%	NC

Cells highlighted yellow indicate that 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.
[1] MY 2021 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 3-6. For the *Childhood Immunization Status* measure, the *Combination 2, 4, 5, 6, 8,* and *9,* indicators were retired for MY 2021; therefore, there were no prior year rates to compare to and no available benchmarks. All combination rates for the *Childhood Immunization Status* measure demonstrated a decline of more than 30 percent for MY 2021, and the applicable vaccination rates demonstrated a decline of more than 10 percent, except for *Hepatitis A, Inactivated Poliovirus Vaccine (IPV),* and *Rotavirus*, which demonstrated a decline of less than 10 percent. Additionally, 17 measure rates fell below the 50th percentile, with 14 of these measure rates falling below the 25th percentile. Conversely, AlohaCare QI met or exceeded the MQD's established Quality Strategy target for HEDIS MY 2021 for the *Child and Adolescent Well-Care Visits—Total* measure indicator.

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

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Child and Adolescent Well-Care Visits				
3–11 Years	45.75%	49.63%	8.48%	★★
12–17 Years	41.53%	46.03%	10.84%	★★★
18–21 Years	16.67%	16.04%	-3.78%	★
Total	39.80%	42.47%	6.71%	★★

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Childhood Immunization Status				
Combination 2	56.69%	37.47%	-33.90%	NC
Combination 3	53.53%	35.77%	-33.18%	★
Combination 4	51.82%	35.52%	-31.46%	NC
Combination 5	45.99%	30.66%	-33.33%	NC
Combination 6	40.15%	25.55%	-36.36%	NC
Combination 7	44.53%	30.41%	-31.71%	★
Combination 8	39.17%	25.30%	-35.41%	NC
Combination 9	34.06%	22.14%	-35.00%	NC
Combination 10	33.33%	21.90%	-34.29%	★
Diphtheria, Tetanus, Pertussis (DTaP)	62.53%	51.34%	-17.90%	★
Hepatitis A	74.45%	67.64%	-9.15%	★
Hepatitis B	74.21%	61.31%	-17.38%	★
Haemophilus Influenzae Type b (HiB)	76.16%	65.94%	-13.42%	★
Influenza	52.31%	46.47%	-11.16%	★★
Inactivated Poliovirus Vaccine (IPV)	76.89%	69.59%	-9.49%	★
Measles, Mumps, and Rubella (MMR)	78.10%	61.07%	-21.81%	★
Pneumococcal Conjugate	59.85%	52.80%	-11.78%	★
Rotavirus	58.64%	56.45%	-3.73%	★
Varicella-Zoster Vaccine (VZV)	78.10%	69.83%	-10.59%	★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	60.38%	59.57%	-1.34%	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.26%	59.23%	-13.23%	★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-7. One rate in this domain (*Cervical Cancer Screening*) demonstrated a relative increase of more than 6 percent for HEDIS MY 2021; however, the rate benchmarked below the 50th percentile. Two of three measure rates that

could be compared to national benchmarks were below the 50th 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 2021. AlohaCare QI met the quality target for both *Prenatal and Postpartum Care* measure rates. In addition, the *Postpartum Care* indicator met or exceeded the 50th percentile.

Table 3-7—AlohaCare QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Cervical Cancer Screening				
Cervical Cancer Screening	50.61%	53.77%	6.24%	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.27%	82.48%	1.49%	★★
Postpartum Care	76.64%	77.62%	1.28%	★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
[1] MY 2021 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 3-8. One rate in this domain reported a relative decrease of more than 8 percent, and one measure rate that could be compared to national benchmarks ranked below the 50th percentile. Conversely, five measure rates benchmarked at or above the 50th percentile. Six measure rates[3-6] within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2021, and AlohaCare QI did not reach the established targets.

Table 3-8—AlohaCare QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Comprehensive Diabetes Care				
HbA1c Testing	82.73%	85.89%	3.82%	★★★
*HbA1c Poor Control (>9.0%)**	39.66%	40.15%	1.24%	★★★
HbA1c Control (<8.0%)	49.64%	48.66%	-1.97%	★★★
Eye Exam (Retinal) Performed	58.15%	53.28%	-8.37%	★★★

[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);* and *Controlling High Blood Pressure—Total*.

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Blood Pressure Control (<140/90 mm Hg)	54.74%	55.72%	1.79%	★★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	9.77%	9.86%	0.92%	NC
65+ Years	12.20%	10.81%	-11.39%	NC
Total	10.00%	9.98%	-0.20%	NC
Controlling High Blood Pressure				
18-64 Years	—	56.09%	—	NC
65-85 Years	—	53.54%	—	NC
Total (18–85 Years)	—	55.47%	—	★★★

** 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.
[1] MY 2021 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 3-9. The *Follow-Up After Hospitalization for Mental Illness—30 Day Follow-Up* indicators demonstrated a relative increase; however, all measure indicator rates for this measure ranked below the 50th percentile, and five of these measure rates fell below the 25th percentile. Of note, all measure indicator rates for *Initiation and Engagement of AOD Abuse or Dependence Treatment, Screening for Depression and Follow-Up Plan,* and *Use of Pharmacotherapy for Opioid Use Disorder,* except for *Oral Naltrexone,* demonstrated a relative increase in performance. AlohaCare QI reached the established MQD Quality Strategy target for four measure rates.

Table 3-9—AlohaCare QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	24.32%	—	★
7-Day Follow-Up—18–64 Years	30.57%	22.28%	-27.12%	★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	30.65%	22.12%	-27.83%	★

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
30-Day Follow-Up—6–17 Years	NA	56.76%	—	★
30-Day Follow-Up—18–64 Years	44.54%	47.28%	6.15%	★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	44.44%	48.23%	8.53%	★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation—Total—13–17 Years	—	36.36%	—	★
Initiation—Total—18+ Years	—	36.56%	—	★
Initiation—Total—Total	—	36.56%	—	★
Engagement—Total—13–17 Years	—	4.55%	—	★
Engagement—Total—18+ Years	—	9.28%	—	★★
Engagement—Total—Total	—	9.18%	—	★
Screening for Depression and Follow-Up Plan				
12–17 Years	20.27%	20.99%	3.55%	NC
18–64 Years	6.65%	12.86%	93.38%	NC
65 Years and Older	12.34%	20.91%	69.45%	NC
18 Years and Older	7.27%	13.73%	88.86%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	48.09%	51.36%	6.80%	NC
Buprenorphine	28.95%	30.86%	6.60%	NC
Oral Naltrexone	1.20%	0.99%	-17.50%	NC
Long-Acting, Injectable Naltrexone	0.00%	0.00%	—	NC
Methadone	20.33%	22.22%	9.30%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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*

Long-Term Services and Supports Performance Measure Results

AlohaCare QI's Long-Term Services and Supports performance measure results are shown in Table 3-10. MY 2021 represented the first year for reporting the measures in this domain; therefore, no prior years' rates are presented. In addition, the measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established.

Table 3-10—AlohaCare QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level
LTSS Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	—	40.63%	—	NC
Care plan with Supplemental Elements Documented	—	40.63%	—	NC
LTSS Minimizing Institutional Length of Stay				
Observed Discharge Rate	—	5.91%	—	NC
Expected Discharge Rate	—	25.35%	—	NC
Observed/Expected Ratio	—	0.23	—	NC
LTSS Shared Care Plan with Primary Care Practitioner				
Shared Care Plan with Primary Care Practitioner	—	41.67%	—	NC

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.

Conclusions and Recommendations

Based on HSAG's analyses of AlohaCare QI's 41 measure rates comparable to benchmarks, nine measure rates (22.0 percent) ranked at or above the 50th percentile. The *Controlling High Blood Pressure—Total* measure rate ranked at or above the 50th percentile, indicating appropriate management of members with high blood pressure. Except for *Blood Pressure Control (<140/90 mm Hg),* all *Comprehensive Diabetes Care* measure rates ranked at or above the 50th percentile, indicating appropriate management for members with diabetes. 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 *First 15 Months of Life—Six or More Well-Child Visits* indicator rate for the *Well-Child Visits in the First 30 Months of Life* measure as well as the *18–21 Years* rate for *Child and Adolescent Well-Care Visits* met or exceeded the 50th percentile, indicating children and adolescent members are receiving the recommended well-child visits.

Conversely, 32 of AlohaCare QI's measure rates comparable to benchmarks (78.1 percent) fell below the 50th percentile, with 24 rates (58.5 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across most domains of care. Additionally, AlohaCare QI met eight of the MQD Quality Strategy targets for HEDIS MY 2021. 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
  - *Child and Adolescent Well-Care Visits—18–21 Years*

  - *Childhood Immunization Status—Combination 3, Combination 7, Combination 10, DTaP, Hepatitis A, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, Rotavirus,* and *VZV*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Ages 15 Months to 30 Months—Two or More Well-Child Visits*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness*—all *7-Day Follow-Up* and *30-Day Follow-Up* measure rates except for *30-Day Follow-Up—18–64 Years,* which ranked below the 50th percentile
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment*—all rates except *Engagement—Total—18+ Years*, which ranked below the 50th percentile

Validation of Performance Improvement Projects

In CY 2022, the MQD selected two new PIPs for the health plans to complete. The selected PIP topics were *Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2022 submission, the health plans progressed to the Design and Implementation stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The health plan will be assessed for improvement in outcomes (Step 9) in the next validation cycle.

Table 3-11 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-11—CY 2022 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design and Implementation Stage (Steps 1 through 8)	07/01/2021 to 09/30/2021	Baseline
Plan All-Cause Readmissions	PIP Design and Implementation Stage (Steps 1 through 8)	CY 2021	Baseline

The focus of the nonclinical *Behavioral Health Coordination* PIP is to integrate care between the Department of Health (DOH) Behavioral Health Services Administration divisions, CCS, and the QI health plans. This includes developing an infrastructure to streamline communication, information sharing, and continuity and coordination of care across agencies that provide services for a population with SPMI, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by the MQD in consultation with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG.

The focus of the clinical *Plan All-Cause Readmissions* PIP is to decrease unplanned member readmission rates. The performance indicator for this PIP is based on the HEDIS *PCR* measure.

Findings

Table 3-12 illustrates the validation results for the two PIPs submitted by AlohaCare QI for the CY 2022 validation.

Table 3-12—CY 2022 PIP Validation Results for AlohaCare QI

PIP Topic	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Behavioral Health Coordination	100%	100%	*Met*
Plan All-Cause Readmissions	100%	100%	*Met*

[1]**Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[2]**Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3]**Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

For both PIPs, AlohaCare QI received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 100 percent for overall evaluation elements across all steps completed and validated.

Design (Steps 1-6)

Behavioral Health Coordination

AlohaCare QI met 100 percent of the requirements in the Design stage, Steps 1 through 6 for the BH PIP. The selected PIP topic was required by the MQD. The MQD held workgroup sessions with HSAG, health plans, and DOH Behavioral Health Services Administration divisions to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. AlohaCare QI documented the PIP design accurately and as discussed during the workgroup meetings. AlohaCare QI's data collection process as documented appeared methodologically sound; however, the data collection process was not comprehensive at the time of the PIP submission. AlohaCare QI was in the process of defining its workflows to capture the denominator data for all the trigger events identified in Indicator 1. Additionally, the data sharing processes with CCS and DOH Behavioral Health Services Administration divisions were to be determined.

Plan All-Cause Readmissions

AlohaCare QI met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. AlohaCare QI's Aim statement set the focus of the PIP and the framework

for data collection and analysis of results. AlohaCare QI clearly defined the eligible population and the performance indicator, which aligned with the HEDIS specifications. AlohaCare QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

AlohaCare QI reported the baseline rates as available for the two performance indicators. AlohaCare QI documented its quality improvement efforts, which included partnering and facilitating workgroup meetings with other health plans and working with its leadership team to determine a workflow for ongoing communication and information sharing.

Plan All-Cause Readmissions

AlohaCare QI accurately reported the baseline numerator, denominator, and percentage for the performance indicator. AlohaCare QI conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes.

Analysis of Results

Table 3-13 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-13—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 9 D: 75	12.0%		
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 0 D: 663	0.0%		

N–Numerator D–Denominator

The rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 12.0 percent. The health plan documented that only formal combined reviews were counted in the numerator for Indicator 1. Additionally, the health plan was in the process of defining its processes to capture the data for all the eligible trigger events identified in the Indicator 1 denominator. The baseline data may be updated by

the health plan in the next annual submission once the processes for capturing data for all the trigger events and combined reviews are determined.

The rate for the percentage of shared members whose data were actively shared with the partner agencies during the baseline measurement period was 0.0 percent. The health plan documented that at the time of the PIP submission, the health plan did not have a mechanism in place to actively share data with partnering agencies. As defined by the performance indicator specification, active data sharing is defined as email, automatic data sharing through systems, or other mechanisms of sharing data. Mechanisms for actively sharing data were in the process of being researched and developed by the health plan.

Table 3-14 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-14—Performance Improvement Project Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. Percentage of eligible discharges for which members 18–64 years of age had at least one acute readmission for any diagnosis within 30 days of the index discharge date.	N: 178 D: 2,000	8.9%		

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date was 8.9 percent. The health plan will be assessed for statistically significant improvement in the performance indicator rate in the next annual submission.

Barriers/Interventions

A health plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions documented by the health plans for appropriateness to the barriers identified and the timeliness of the implementation of the interventions.

Table 3-15 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-15—Interventions Implemented/Planned for AlohaCare QI PIPs

PIP Topic	Barriers	Interventions
Behavioral Health Coordination	1. Inadequate care coordination and integrated care approach among partnering agencies for shared members.	1. Drafting and executing memorandums of understanding (MOUs) with the

PIP Topic	Barriers	Interventions
		partnering agencies regarding data sharing.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*
Plan All-Cause Readmissions	1. Barrier to access to care on neighbor islands due to lack of providers. 2. Unable to quickly identify which members are at high risk for readmission. 3. Unclear process or program to identify all discharges from acute facilities and member discharge needs.	1. Expansion of the transition of care (TOC) services in the post-discharge program; increase in staff to provide outreach to more members and enable the assessment and procurement of member's immediate needs. 2. Creation of a predictive analytics tool by Health Catalyst. Creation of an interdepartmental TOC workflow for referrals and outreach beginning at admission to follow up post-discharge. 3. Health Catalyst tool created for TOC program includes the status of members who are inpatient with only a 24-hour possible lag time. Develop a TOC referral workflow that includes notification of anticipated discharge date and supports if known.

* The documented interventions are required by the MQD.

Strengths

- For both PIPs, AlohaCare QI received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- For the *Behavioral Health Coordination* PIP, the health plan initiated facilitating workgroup meetings with other health plans and working with its leadership team to determine a workflow for ongoing communication and information sharing with partnering agencies.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the reported data for the two performance indicators were incomplete. The health plan should work toward improving its data capturing and sharing capabilities with partnering agencies and in accordance with the PIP specifications.

- For the *Behavioral Health Coordination* PIP, AlohaCare QI should ensure that in addition to the other health plans, it also discusses data sharing with DOH Behavioral Health Services Administration divisions.
- For the *Plan All-Cause Readmissions* PIP, AlohaCare QI should initiate interventions identified by the Readmissions Collaborative workgroup.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- The health plan should continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP:
  - The health plan should document its progress toward implementing the interventions.
  - The baseline data for the performance indicators should be updated as the health plan determines the information sharing and data collection processes for all the trigger events and with all the partnering agencies.
  - Even though the PIP measurement periods are based on the third quarter in a calendar year, the health plan should collect the performance indicators' data on a quarterly basis and report quarterly data in Step 7 of the PIP Submission Form.
  - The health plan should capture the informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The health plan should update Step 3 and Step 5 of the PIP Submission Form with any changes made to the performance indicator specifications; for example, the combined review trigger events that were approved by the MQD should be updated in the next annual submission.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan should document the barriers, interventions, and quality improvement activities undertaken as part of the Readmissions Collaborative workgroup to improve the *PCR* rate.
- The health plan should continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions. The health plan should consider using science-based quality improvement tools, such as process mapping and FMEA for barrier analysis.
- The health plan should have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- The health plan must address the validation feedback associated with any *Met* score prior to the next annual submission.
- The health plan should seek technical assistance from HSAG and the MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-16 presents the 2022 percentage of top-box responses (i.e., top-box scores) for AlohaCare QI compared to the 2021 NCQA adult Medicaid national averages and the corresponding 2020 scores.[3-7, 3-8] Additionally, the overall member experience ratings (i.e., star ratings) resulting from AlohaCare QI's top-box scores compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-9]

Table 3-16—Adult Medicaid CAHPS Results for AlohaCare QI

Measure	2020 Scores	2022 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	63.2%	59.8%	★★
Rating of All Health Care	53.9%	56.0%	★★
Rating of Personal Doctor	70.9%	64.1%	★
Rating of Specialist Seen Most Often	69.6%	70.6%	★★★
Composite Measures			
Getting Needed Care	75.1%	79.2%	★
Getting Care Quickly	74.4%	75.5%	★
How Well Doctors Communicate	93.9%	90.7%	★
Customer Service	87.7%	83.9%	★
Individual Item Measure			
Coordination of Care	86.2%+	78.9%+	★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2021 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2021 NCQA adult Medicaid national averages.

▲ Indicates the 2022 score is statistically significantly higher than the 2020 score.

▼ Indicates the 2022 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

3-7 The adult population was last surveyed in 2020; therefore, the 2022 adult CAHPS scores are compared to the corresponding 2020 scores.

3-8 National Committee for Quality Assurance. *HEDIS® Measurement Year 2021, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2021.

3-9 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

Strengths

None of the 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages or 2020 top-box scores for any measure; therefore, no substantial strengths were identified.

Areas for Improvement

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. AlohaCare QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-17 provides a summary of the key drivers identified for AlohaCare QI.

Table 3-17—AlohaCare QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Q6. Received appointment for a checkup or routine care as soon as needed	✓		
Q9. Ease of getting the care, tests, or treatment needed		✓	
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	✓	✓	✓
Q20. Received appointment with a specialist as soon as needed	✓		**N/A**
Q24. Health plan's customer service gave 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 and timeliness for AlohaCare QI:

- Respondents reported not always receiving an appointment for a checkup or routine care as soon as they needed.
- Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their plan.
- Respondents reported not always receiving an appointment with a specialist as soon as they needed.

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

- Respondents reported that 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.

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

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 five EQR activities. While the compliance monitoring review and network adequacy activities revealed that AlohaCare QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

AlohaCare QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. AlohaCare QI's performance during the 2022 compliance review was average, meeting or exceeding the statewide compliance score for four of the eight standards. AlohaCare QI achieved 100 percent compliance in three standards and 90 to 97 percent in four standards. AlohaCare QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.

AlohaCare QI maintained robust systems for updating, verifying, storing, and sharing provider network data in accordance with State expectations. HSAG's CY 2022 NAV findings suggest that AlohaCare QI's current provider network data systems and processes, as reported by the health plan in the PDSQ, are sufficient to support future NAV activities.

Overall, more than three quarters (78.1 percent) of AlohaCare QI's performance measure rates fell below the 50th percentile across all domains, with more than half (58.5 percent) falling below the 25th percentile. While some measures showed improvement from HEDIS MY 2020, AlohaCare QI's performance suggested several areas in need of improvement, including the Children's Preventive Health and Behavioral Health domains. Only eight of AlohaCare QI's measure rates met the MQD Quality Strategy targets.

AlohaCare QI's CAHPS results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower in 2022 than in 2020, and none of the measures scored statistically significantly lower than the 2021 NCQA adult Medicaid national averages, the following eight measures were below the 50th percentiles: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. These results indicate the need for AlohaCare QI to implement improvement strategies to ensure members have high-quality care and timely access to care.

While none of the three measures the MQD selected for monitoring within its Quality Strategy met or exceeded the 75th percentiles, AlohaCare QI should focus improvement efforts on the measures that fell below the 25th percentile (*Getting Needed Care* and *How Well Doctors Communicate*).

Finally, AlohaCare QI progressed to the Design and Implementation stages of the two new PIP topics selected in CY 2022. The topics addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, AlohaCare QI received an overall *Met* validation status. The health plan was partnering and facilitating workgroup meetings with other health plans and working with its leadership team to determine a workflow for ongoing communication and information sharing with partnering agencies.

For the *Plan All-Cause Readmissions* PIP, AlohaCare QI received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The health plan will be assessed for improvement in outcomes in the next validation cycle.

Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

Compliance Monitoring Review

The 2022 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-18 presents the standards and compliance scores for HMSA QI.

Table 3-18—Standards and Compliance Scores—HMSA QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Availability of Services	17	17	17	0	0	0	100%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	0	100%
III	Coordination and Continuity of Care	10	10	9	1	0	0	95%
IV	Confidentiality	9	9	9	0	0	0	100%
V	Coverage and Authorization of Services	31	31	30	1	0	0	98%
VI	Enrollee Information	19	19	15	4	0	0	89%
VII	Enrollee Rights and Protections	8	8	8	0	0	0	100%
VIII	Grievance and Appeal System	31	31	26	5	0	0	92%
	Totals	**128**	**128**	**117**	**11**	**0**	**0**	**96%**

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

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

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

Strengths

HMSA QI was found to be 100 percent compliant with the Availability of Services and Assurances of Adequate Capacity and Services standards. HMSA QI had policies and procedures in place to monitor its network and ensure that all covered services were available and accessible to its members in a timely manner and met the standards developed by the State for network adequacy. Services included in the contract were made available to members 24 hours a day, seven days a week, when medically necessary.

HMSA QI conducted ongoing monitoring of its network, which included the review of a dashboard for any significant provider changes or losses and evaluation of specialist ratios to identify provider gaps.

The health plan was also fully compliant with the Confidentiality and Enrollee Rights and Protections standards. HMSA QI demonstrated that it had in place policies and procedures that addressed the use and disclosure of PHI and PII. All newly hired staff members were required to receive Health Insurance Portability and Accountability Act (HIPAA) training at the time of hire and on an annual basis. HMSA QI had monitoring mechanisms that ensured that PHI and PII were safeguarded and released only with a member's authorization and in alignment with applicable federal regulations. HMSA QI had policies, procedures, manuals, and other written member and provider information regarding member rights. The health plan, through training and education, ensured that staff members and providers were informed of member rights and responsibilities. Ongoing monitoring of complaints and grievances related to suspected rights violations occurred to ensure that staff members and providers adhered to and protected member rights.

The health plan also scored high in the Coverage and Authorization of Services standard, with 98 percent compliance and only one of the 31 elements scoring *Partially Met.* HMSA QI's policies and procedures met the requirements for providing and paying for emergency, urgent, and poststabilization services; for ensuring consistent application of UM criteria (by conducting interrater reliability reviews); and for providing the required covered array of Medicaid services. HMSA QI provided evidence that it had the appropriate mechanisms in place for receiving, reviewing, processing, and monitoring service authorization decisions for members and providers. A review of service denials demonstrated that the files were well organized and provided evidence that HMSA QI not only monitored its internal utilization management processes, but also monitored its delegates to ensure timeliness and consistency of authorization decisions. All decisions were made within the required time frames and by providers with the appropriate clinical expertise. The NABDs were written in a manner that was easily understood, at or below a sixth-grade reading level, and sent to the member and requesting provider.

Finally, HMSA QI was found to be 95 percent compliant with the Coordination and Continuity of Care standard, with only one element scoring *Partially Met*. HMSA QI had comprehensive policies, procedures, processes, and staff in place to deliver and coordinate the care of its members. HMSA QI demonstrated the implementation of its policies and procedures, and ability to coordinate the care of its members, through a review of care coordination files. The files were well organized and provided evidence that members were involved in the development of the HAP, health coordinators ensured member privacy was protected during care coordination activities, and that the HAP and any other relevant information was shared with the member's PCP and other involved providers. All HAPs were completed within 30 days of completion of the initial HFA. Members were provided the contact information of their assigned health coordinator and were also able to send messages directly to the health coordinator through HMSA QI's member portal.

Areas for Improvement

HMSA QI was found to be 92 percent compliant with the Grievance and Appeal System standard, with five elements scoring *Partially Met.* HMSA QI had well-defined policies, procedures, and systems for

logging, tracking, and reporting member grievances and appeals. The health plan maintained several staff members responsible for the processing of grievances and appeals. The corrective actions required by HMSA QI were related to policy, procedure, and process revisions to ensure that the health plan receives written consent from the member if a provider or authorized representative wishes to file an appeal on behalf of the member and to ensure that the required member notifications are made if a grievance resolution time frame is extended or when an expedited appeal resolution is made.

HMSA QI was found to be 89 percent compliant with the Enrollee Information standard, with four elements scoring *Partially Met.* In general, HMSA QI had member information, customer service staff members, and service coordinators available to help members understand the requirements and benefits of the plan. The corrective actions required by HMSA QI were related to updates needed to the member portal, updates to policies and procedures in the event of a provider termination, updates to the member handbook to ensure it included information about the specific locations for emergency settings, and updates to the provider directory to include specific details regarding providers' office accommodations for people with physical disabilities.

Validation of Network Adequacy

Findings

Provider data structure: HMSA QI maintained two databases for storing Medicaid provider information (eVIPs and QNXT). Both databases had normalized data structures and were maintained primarily via manual user updates. eVIPs was used to store demographic, credentialing, contracting, and plan participation data, while QNXT was used to process claims.

Delegated services: HMSA QI reported delegating some services (i.e., contracting all or part of the provision of selected services, such as BH services) to another entity. Table 3-19 summarizes HMSA QI's delegated provider type/services, delegated entity names, and the frequency with which the health plan received provider data from the delegated entity at the time of the questionnaire response.

Table 3-19—HMSA QI Delegated Services

Provider Type/Service	Delegated Entity Name	Provider Data Frequency
Vision	EyeMed	The vendor supplies a biweekly network file to HMSA QI in Excel format.
Pharmacy	CVS	The vendor supplied the following Excel files: • Daily HMSA QI Medicaid State Roster file • Weekly HMSA QI add/term report • Weekly report of Medicaid directory file

Regarding oversight of all delegated services, HMSA QI reported that it received a biweekly network Excel file from EyeMed, which HMSA QI processed to update its eVIPs provider database. This information was included in the quarterly PNA reports that HMSA QI sent to MQD. There was a separate monthly kickout report for any incomplete EyeMed provider records, which HMSA QI then

investigated and updated, if necessary. Additionally, EyeMed conducted a separate, quarterly GeoAccess report.

CVS contracted directly with the pharmacies and owns the pharmacy network. Once the QI request for proposal (RFP) was released, CVS conducted a GeoAccess report to ensure compliance with RFP requirements described in the Provider Services policy supplied to HSAG in HMSA QI's PDSQ responses. Following this, CVS sent a weekly listing of the pharmacies in CVS' Medicaid directory network and an ad hoc add/term file of pharmacies entering and leaving the network to HMSA QI to ensure continued network adequacy. These files were reviewed by the Medicaid pharmacist and stored for tracking purposes. The Medicaid pharmacist assessed and tracked changes in CVS' pharmacy network. Additionally, HMSA QI submitted files to CVS to ensure that Hawaii's Online Kahu Utility (HOKU) registration is accounted for in the approved Medicaid network.

Provider classification data collection and maintenance: HMSA QI submitted information on selected provider categorization fields and supplied a corresponding data dictionary, as requested. Table 3-20 details all provider classifications used by HMSA QI, as well as the mechanism for reporting and frequency of updating these classifications.

Table 3-20—HMSA QI Provider Classifications

Provider Classification	Reporting Mechanism	Update Frequency
Provider Type	Providers self-reported, HMSA QI primary source verified.	Providers were required to update or confirm information quarterly.
Provider Specialty	Providers self-reported, HMSA QI primary source verified.	Providers were required to update or confirm information quarterly.
Provider Taxonomy	Internal crosswalk based on HMSA QI specialty.	Daily.
Degree Attained (e.g., MD, RN, etc.)	Providers self-reported, HMSA QI primary source verified.	Providers were required to update or confirm information quarterly.
Licenses and Certifications for Individuals and/or Facilities	Providers self-reported, HMSA QI primary source verified.	Varies based on license cycle.

Provider indicators: HSAG asked each health plan to specify whether its provider data system included fields for the following provider indicators: PCP, Prenatal Care Providers, BH Providers, HCBS Providers, Active/Inactive Providers, Telehealth Providers, and SUD Providers, including those offering MAT. Table 3-21 details HMSA QI's reported responses and additional information regarding provider indicators.

Table 3-21—HMSA QI Provider Indicators

Provider Indicators	In Data System?	If Yes, Methods for Classifying Providers
PCPs	Yes	All providers with a provider specialty of Family Practice, Internal Medicine, Geriatrics, Pediatrics, APRN, or PA.
Prenatal Care Providers	No	
Behavioral Health Providers	Yes	All providers with a provider specialty of App Behavioral Analyst – Board Certified Behavioral Analyst (BCBA), App Behavioral Analyst – Board Certified Behavioral Analyst – Doctoral (BCBA-D), Child Psychiatry, Marriage & Family Therapist, Mental Health Counselor, Psychiatric/Mental Health Nurse Practitioner, Psychiatry, Psychology, or Social Worker.
SUD Treatment Providers, including providers offering MAT	Yes	All providers with a provider specialty of Addiction Medicine, Substance Abuse, Intensive Outpatient Clinics, or Chemical Dependency.
HCBS Providers	Yes	All providers with provider specialty of Adult Day Care, Adult Day Health, Community Care Management Agency, Counseling and Training, Home Delivered Meals, Personal Assistance, Personal Emergency Response Systems (PERS), or Private Duty Nursing.
Active/Inactive Providers	Yes	Active/Terminated Providers.
Telehealth Providers	Yes	Telehealth Y/N.

Providers accepting new patients: HMSA QI confirmed that its provider data system included fields to identify providers accepting new patients for all rendering providers.

Panel capacity: HMSA QI confirmed that its provider data system did not include fields to identify a provider's panel capacity.

Use of single case agreements: HMSA QI reported using LOAs with nonparticipating providers rendering services that were not available from participating providers. HMSA QI reported that, generally, Medical Management (MM) would not request an LOA if the member has nonparticipating benefits. HMSA QI would complete an LOA if there was no participating provider available to provide the covered benefit to the member.

MM completed the LOA form and submitted it to Contracting and Facility Reimbursement for processing. Once an LOA was signed, Contracting and Facility Reimbursement would email the executed LOA to all necessary parties, including MM. MM documented the receipt of executed LOA in the Aerial. MM did not keep a list of providers that required an LOA or list of cases that had an LOA.

Provider network monitoring: HMSA QI reported that its primary tool for monitoring network adequacy was the PNA report submitted to MQD on a quarterly basis. In addition to the newly formed metrics for the PNA report, HMSA QI also conducted a monthly monitoring process that included

measuring its network compared to RFP provider-to-member ratios. Provider Services also held a monthly meeting with HMSA QI's Health Coordination Services team to discuss any access-related concerns that members were experiencing.

Annually, HMSA QI also performed more in-depth analysis for both provider-to-member ratios and time and distance standards for PCPs, high-volume specialists, and high-impact specialists. This, along with HMSA QI's monthly monitoring activities, was documented in the QI Provider Selection, Retention, Recruitment, and Availability policy provided to HSAG in HMSA QI's PDSQ responses.

Health plan's provider data verification and cleaning: HMSA QI reported that its Provider Data Maintenance (PDM) team verified all provider addresses via the United States Postal Service (USPS) site to ensure address validity prior to updating its systems. Every quarter, HMSA QI surveyed its providers and asked that they attest to and/or update their demographic information, including physical locations, contact information, and patient panel status.

Credentials verification was performed using the primary source of the credentials or an NCQA-approved source, such as the State of Hawaii Department of Commerce and Consumer Affairs, Professional Vocational Licensing Division; the Regulated Industry Complaints Office (RICO); and the Drug Enforcement Administration (DEA).

Communicating provider network information to members: HMSA QI reported that its provider information was shared with HMSA QI members on the online provider directory. The directory did not include hospitalists, out-of-state providers, or self-directed providers. Members could access services not shown on the online directory through provider referral or by receiving emergency services. Subsequently, if members were looking to identify providers not displayed on the directory themselves, they were able to contact HMSA QI's Customer Relations (CR) department or Health Coordination Services (HCS) department to access those services.

Strengths

HMSA QI maintained detailed data regarding provider classifications (e.g., provider type, specialty, network participation, etc.) and reported multiple methods for updating, verifying, and cleaning provider data. HMSA QI also utilized multiple methods for monitoring its provider network and communicating provider network information to members.

Areas for Improvement

HMSA QI did not maintain data fields to identify prenatal care providers and did not collect data regarding provider panel capacity.

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 six standard supplemental data sources and four nonstandard data sources to review for MY 2021 reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2021 performance measure reporting.

HMSA QI was required to undergo convenience sample validation for the *Controlling High Blood Pressure, Comprehensive Diabetes Care—HbA1c Rates,* and *Childhood Immunization Status—DtaP* measure indicators. All cases successfully passed the validation process.

The final MRRV was conducted for *Controlling High Blood Pressure, Comprehensive Diabetes Care—HbA1c Control (<8.0%),* and *Childhood Immunization Status—Combination 7.* HMSA QI passed the MRRV for all cases with no critical errors.

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 denominators were 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 3-22. The one rate in this domain that could be compared to national benchmarks ranked at or above the 90th percentile. All three rates for the non-HEDIS *Heart Failure Admission Rate* measure demonstrated a relative decline in performance. Of note, the rate for ages 65 and older declined more than 50 percent. One measure in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total*), and HMSA QI did not reach the target for HEDIS MY 2021.

Table 3-22—HMSA QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Heart Failure Admission Rate*				
18-64 Years	21.52	22.09	2.65%	NC
65+ Years	63.03	94.66	50.18%	NC
Total	23.84	26.49	11.12%	NC

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	7.99%	7.72%	-3.38%	★★★★★
Expected Readmissions—Total	9.57%	9.44%	-1.36%	NC
*Index Total Stays—O/E Ratio—Total**	0.83	0.82	-1.45%	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.
[1] MY 2021 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 3-23. All measure rates for the *Child and Adolescent Well-Care Visits* and *Well-Child Visits in the First 30 Months of Life* measures ranked at or above the 50th percentile, as well as the *Childhood Immunization Status—Combination 10* and *Influenza* measure rates. Of note, the *Child and Adolescent Well-Care Visits—12–17 Years* and *Well-Child Visits in the First 30 Months of Life—First 15 Months of Life—Six or More Well-Child Visits* rates ranked at or above the 75th percentile. Conversely, 11 of the *Childhood Immunization Status* rates fell below the 25th percentile. Two measures in this domain had an MQD Quality Strategy target for HEDIS MY 2021 (*Childhood Immunization Status—Combination 3* and *Child and Adolescent Well-Care Visits—Total*), and HMSA QI met the established target for *Child and Adolescent Well-Care Visits—Total*.

Table 3-23—HMSA QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Child and Adolescent Well-Care Visits				
3–11 Years	55.78%	56.18%	0.72%	★★★
12–17 Years	52.69%	56.36%	6.97%	★★★★
18–21 Years	27.22%	26.69%	-1.95%	★★★
Total	50.26%	51.06%	1.59%	★★★
Childhood Immunization Status				
Combination 2	71.29%	63.26%	-11.26%	NC
Combination 3	68.61%	61.31%	-10.64%	★
Combination 4	66.91%	60.83%	-9.09%	NC
Combination 5	56.20%	51.58%	-8.22%	NC

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Combination 6	49.15%	46.72%	-4.94%	NC
Combination 7	55.23%	51.09%	-7.50%	★
Combination 8	48.91%	46.72%	-4.48%	NC
Combination 9	41.36%	40.15%	-2.93%	NC
Combination 10	41.12%	40.15%	-2.36%	★★★
DTaP	76.89%	69.34%	-9.82%	★
Hepatitis A	86.37%	78.35%	-9.29%	★
Hepatitis B	82.24%	75.91%	-7.70%	★
HiB	89.29%	79.81%	-10.62%	★
Influenza	58.64%	55.47%	-5.41%	★★★
IPV	87.10%	78.59%	-9.77%	★
MMR	89.54%	79.08%	-11.68%	★
Pneumococcal Conjugate	76.40%	69.59%	-8.91%	★
Rotavirus	70.32%	64.96%	-7.62%	★
VZV	87.35%	78.10%	-10.59%	★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	67.17%	67.56%	0.58%	★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	78.88%	72.86%	-7.63%	★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-24. One measure rate in this domain (*Prenatal and Postpartum Care—Postpartum Care*) reported a relative improvement of more than 6 percent in HEDIS MY 2021, and one rate (*Cervical Cancer Screening*) demonstrated a relative decline in performance of 11 percent and fell below the 50th percentile. Conversely, HMSA QI met or exceeded the MQD's HEDIS MY 2021 Quality Strategy targets for the *Prenatal and Postpartum Care* measure rates.

Table 3-24—HMSA QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Cervical Cancer Screening				
Cervical Cancer Screening	64.17%	57.11%	-11.00%	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	83.45%	84.48%	1.23%	★★
Postpartum Care	72.02%	76.72%	6.53%	★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
[1] MY 2021 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 3-25. Four measure rates that could be compared to national benchmarks ranked at or above the 50th percentile, one of which ranked at or above the 90th percentile. HMSA QI demonstrated a relative increase in performance of more than 9 percent for the non-HEDIS *Concurrent Use of Opioids and Benzodiazepines—18–64* and *Total*. Conversely, the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Controlling High Blood Pressure—Total* measure rates ranked below the 50th percentile. HMSA QI met the HEDIS MY 2021 MQD Quality Strategy target for *Concurrent Use of Opioids and Benzodiazepines—Total.*

Table 3-25—HMSA QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Comprehensive Diabetes Care				
HbA1c Testing	82.73%	84.63%	2.30%	★★★
*HbA1c Poor Control (>9.0%)**	34.55%	39.76%	15.08%	★★★
HbA1c Control (<8.0%)	53.77%	48.05%	-10.64%	★★★
Eye Exam (Retinal) Performed	63.26%	64.63%	2.17%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	57.42%	54.39%	-5.28%	★★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	14.50%	13.10%	-9.66%	NC
65+ Years	9.30%	9.42%	1.29%	NC
Total	14.24%	12.90%	-9.41%	NC

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Controlling High Blood Pressure				
18-64 Years	—	53.80%	—	NC
65-85 Years	—	55.38%	—	NC
Total (18-85 Years)	—	54.05%	—	★★

Cells highlighted yellow indicate that 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.
[1] MY 2021 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 3-26. All of the *Screening for Depression and Follow-Up Plan* measure rates demonstrated a relative increase in performance, three of which were more than 13 percent. Overall, the *Follow-Up After Hospitalization for Mental Illness* measure rates demonstrated a relative decrease; however, three measure rates (*7-Day Follow-Up—18–64 Years, 30-Day Follow-Up—18–64 Years,* and *30-Day Follow-Up—Total*) still ranked at or above the 50th percentile, and the *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* rates both reached the MQD's Quality Strategy target for HEDIS MY 2021. Three measure rates that could be compared to national benchmarks ranked at or above the 50th percentile; nine rates fell below the 50th percentile, three of which fell below the 25th percentile. The *Use of Pharmacotherapy for Opioid Use Disorder— Buprenorphine* and *Long Acting, Injectable Naltrexone* measure rates demonstrated a relative increase and reached the MQD's Quality Strategy targets. Of note, the *Long-Acting, Injectable Naltrexone* rate showed a relative increase of 80 percent. Conversely, the *Oral Naltrexone* rate demonstrated a relative decline of more than 33 percent. Additionally, HMSA QI met the MQD Quality Strategy target for HEDIS MY 2021 for seven measure rates within this domain.

Table 3-26—HMSA QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	47.34%	46.11%	-2.60%	★★
7-Day Follow-Up—18–64 Years	40.20%	35.80%	-10.95%	★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	41.80%	38.48%	-7.94%	★★

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
30-Day Follow-Up—6–17 Years	67.46%	67.22%	-0.36%	★★
30-Day Follow-Up—18–64 Years	58.80%	58.56%	-0.41%	★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	60.86%	60.66%	-0.33%	★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation—Total—13–17 Years	—	38.84%	—	★
Initiation—Total—18+ Years	—	37.64%	—	★
Initiation—Total—Total	—	37.67%	—	★
Engagement—Total—13–17 Years	—	12.40%	—	★★
Engagement—Total—18+ Years	—	13.56%	—	★★
Engagement—Total—Total	—	13.53%	—	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	47.25%	48.81%	3.30%	NC
18–64 Years	23.96%	27.28%	13.86%	NC
65 Years and Older	25.38%	29.20%	15.05%	NC
18 Years and Older	24.04%	27.40%	13.98%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	50.68%	50.91%	0.45%	NC
Buprenorphine	32.74%	33.88%	3.48%	NC
Oral Naltrexone	1.63%	1.09%	-33.13%	NC
Long-Acting, Injectable Naltrexone	0.20%	0.36%	80.00%	NC
Methadone	18.00%	17.39%	-3.39%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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*

Long-Term Services and Supports Performance Measure Results

HMSA QI's Long-Term Services and Supports performance measure results are shown in Table 3-27. MY 2021 represented the first year for reporting the measures in this domain; therefore, no prior years' rates are presented. In addition, the measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established. All measures in this domain were determined to be *Reportable*; however, for the *LTSS Minimizing Institutional Length of Stay* measure, HMSA QI did not have enough members

in its eligible population to report a valid rate; therefore, a status of *NA* (i.e., small denominator) was assigned.

Table 3-27—HMSA QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level
LTSS Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	—	3.13%	—	NC
Care plan with Supplemental Elements Documented	—	3.13%	—	NC
LTSS Minimizing Institutional Length of Stay				
Observed Discharge Rate	—	NA	—	NC
Expected Discharge Rate	—	NA	—	NC
Observed/Expected Ratio	—	NA	—	NC
LTSS Shared Care Plan with Primary Care Practitioner				
Shared Care Plan with Primary Care Practitioner	—	59.38%	—	NC

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

Conclusions and Recommendations

Based on HSAG's analyses of HMSA QI's 41 measure rates comparable to benchmarks, 16 measure rates (39.0 percent) ranked at or above the 50th percentile, with two of these rates (4.9 percent) ranking at or above the 75th percentile and two rates (4.9 percent) ranking at or above the 90th percentile, indicating positive performance in providing timely access to postpartum care services, appropriate well-child visits for children and adolescents, timely receipt of childhood immunizations, appropriate monitoring of eye exams and control of HbA1c levels for diabetic members, and appropriate monitoring of members ages 18–64 years of age who were hospitalized for a mental health illness. Additionally, HMSA QI met 11 of the MQD Quality Strategy targets for HEDIS MY 2021.

Conversely, 24 of HMSA QI's measure rates comparable to benchmarks (58.5 percent) fell below the 50th percentile, with 14 rates (34.2 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 3, Combination 7, DTAP, Hepatitis A, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, Rotavirus,* and *VZV*
- Behavioral Health
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—13–17 Years, Initiation—Total—18+ Years,* and *Initiation—Total—Total*

Validation of Performance Improvement Projects

In CY 2022, the MQD selected two new PIPs—*Behavioral Health Coordination* and *Plan All-Cause Readmissions* for all the health plans to complete. For the CY 2022 submission, the health plans progressed to the Design and Implementation stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The health plan will be assessed for improvement in outcomes (Step 9) in the next validation cycle.

Table 3-28 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-28—CY 2022 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design and Implementation Stage (Steps 1 through 8)	07/01/2021 to 09/30/2021	Baseline
Plan All-Cause Readmissions	PIP Design and Implementation Stage (Steps 1 through 8)	CY 2021	Baseline

The focus of the nonclinical *Behavioral Health Coordination* (BH) PIP is to integrate care between the DOH Behavioral Health Services Administration divisions, CCS, and the QI health plans. This includes developing an infrastructure to streamline communication, information sharing, and continuity and coordination of care across agencies that provide services for a population with severe persistent mental illness, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by the MQD in consultation with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG.

The focus of the clinical *Plan All-Cause Readmissions* PIP is to decrease unplanned member readmission rates. The performance indicator for this PIP is based on the HEDIS *PCR* measure.

Findings

Table 3-29 illustrates the validation results for the two PIPs submitted by HMSA QI for CY 2022 validation.

Table 3-29—CY 2022 PIP Validation Results for HMSA QI

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	100%	100%	*Met*
Plan All-Cause Readmissions	93%	100%	*Met*

For the *Behavioral Health Coordination* PIP, HMSA QI received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 100 percent for overall evaluation elements across all steps completed and validated.

For the *Plan All-Cause Readmissions* PIP, HMSA QI received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 93 percent of overall evaluation elements across all steps completed and validated.

Design (Steps 1-6)

Behavioral Health Coordination

HMSA QI met 100 percent of the requirements in the Design stage, Steps 1 through 6 for the BH PIP. The selected PIP topic was required by the MQD. The MQD held workgroup sessions with HSAG, health plans, and DOH Behavioral Health Services Administration divisions to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. HMSA QI documented the PIP design accurately and as discussed during the workgroup meetings. HMSA QI's data collection process as documented appeared methodologically sound; however, the data collection process was not comprehensive at the time of the PIP submission. HMSA QI was in the process of defining its workflows to capture the denominator data for all the trigger events identified in Indicator 1. Additionally, the data sharing processes with CCS and DOH Behavioral Health Services Administration divisions were to be determined.

Plan All-Cause Readmissions

HMSA QI met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. HMSA QI's Aim statement set the focus of the PIP and the framework for data collection and analysis of results. HMSA QI clearly defined the eligible population and the performance indicator, which aligned with the HEDIS specifications. HMSA QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

HMSA QI reported the baseline rates as available for the two performance indicators. HMSA QI documented its quality improvement efforts toward implementing the MQD-mandated interventions for this PIP. The health plan indicated that it met regularly with CCS to discuss accomplishing targeted goals. HMSA QI had also started collaboration meetings with the Child & Adolescent Mental Health Division (CAMHD) of the Hawaii DOH on developing a process to identify CAMHD-eligible members who are approaching 21 years of age and are at risk of opting out of behavioral care coordination services.

Plan All-Cause Readmissions

HMSA QI accurately reported the baseline numerator, denominator, and percentage rate for the performance indicator; however, there was a discrepancy in the reported data in the Step 7 data table and the narrative. The health plan should accurately report the data and ensure that they match the health plan's final CY 2021 HEDIS *PCR* measure data. HMSA QI conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes.

Analysis of Results

Table 3-30 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-30—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 7 D: 330	2.1%		
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 206 D: 1,071	19.2%		

N–Numerator D–Denominator

The rate for the percentage of eligible members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 2.1 percent. HMSA QI documented that only formal combined reviews were counted in the numerator. Additionally, HMSA QI

was able to identify some of the qualifying events or diagnoses, which were included in the total denominator count (330). The health plan is working with QI plans and partner agencies to be able to identify and acquire data on other trigger events such as incarcerated members, members going through care transitions, members who opt out of receiving health services when they turn 21 years of age, and members with challenging or breakthrough behavioral issues and substance use disorders. The denominator count will be revised when those data elements become available.

The rate for the percentage of shared members whose data were actively shared with the partner agencies during the baseline measurement period was 19.2 percent. The health plan documented that at the time of the PIP submission, the health plan did not have a mechanism in place to actively share data with all the partnering agencies. Mechanisms for sharing data were in the process of being researched and developed by the health plan.

Table 3-31 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-31—Performance Improvement Project Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. For members 18–64 years of age, the number of acute inpatient and observed stays during the measurement year that were followed up by an unplanned acute readmission for any diagnosis within 30 days	N: 332 D:4,247	7.8%		

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date was 7.8 percent. The health plan will be assessed for statistically significant improvement in the performance indicator rate in the next annual submission.

Barriers/Interventions

A health plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions documented by the health plans for appropriateness to the barriers identified and the timeliness of the implementation of the interventions.

Table 3-32 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-32—Interventions Implemented/Planned for HMSA QI PIPs

PIP Topic	Barriers	Interventions
Behavioral Health Coordination	1. Inadequate care coordination and integrated care approach among partnering agencies for shared members.	1. Drafting and executing MOUs with the partnering agencies regarding data sharing.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*
Plan All-Cause Readmissions	1. Members returning to the emergency room instead of accessing appropriate medical services. 2. Member not regularly seeking care for chronic conditions.	1. Work with discharge planners and internal HMSA case management to educate members on importance of managing chronic conditions. *2.* Ensure member's attributed PCP is correct. Members might be unaware if auto-assigned and do not have a designated PCP. Educate members on the importance of managing chronic conditions provide appointment reminders to members.

* The documented interventions are required by the MQD.

Strengths

- For both PIPs, HMSA QI received an overall *Met* validation status.
- For the *Behavioral Health Coordination* PIP, the health plan had initiated collaborative discussions with CCS and CAMHD.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the reported data for the two performance indicators were incomplete. The health plan should work toward improving its data capturing and sharing capabilities with all the partnering agencies and in accordance with the PIP specifications.
- For the *Behavioral Health Coordination* PIP, HMSA QI should ensure that in addition to the other health plans and CAMHD, it also discusses data sharing with other DOH Behavioral Health Services Administration divisions.
- For the *Plan All-Cause Readmissions* PIP, HMSA QI should ensure the reported data are accurate and the health plan should initiate interventions identified by the Readmissions Collaborative workgroup.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- The health plan should continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP:
  - The health plan should document its progress toward implementing the interventions and expanding the data sharing efforts with all the partnering agencies.
  - The baseline data for the performance indicators should be updated as the health plan determines the information sharing and data collection processes.
  - Even though the PIP measurement periods are based on the third quarter in a calendar year, the health plan should collect the performance indicators' data on a quarterly basis and report quarterly data in Step 7 of the PIP Submission Form.
  - The health plan should capture the informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The health plan should update Step 3 and Step 5 of the PIP Submission Form with any changes made to the performance indicator specifications; for example, the changes to the combined review trigger events that were approved by the MQD should be updated in the next annual submission.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan should document the barriers, interventions, and quality improvement activities undertaken as part of the Readmissions Collaborative workgroup to improve the *PCR* rate.
  - The health plan should accurately report the baseline numerator, denominator, and rate in the Step 7 data table. The health plan should ensure the data matches the health plan's final MY 2021 HEDIS final Interactive Data Submission System (IDSS) file for the PCR rate. The health plan should also attach the MY 2021 IDSS file with its next annual PIP submission for reference.
- The health plan should continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- The health plan should have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- The health plan must address the validation feedback associated with any *Met* score and the *Partially Met* comments in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and the MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-33 presents the 2022 percentage of top-box responses (i.e., top-box scores) for HMSA QI compared to the 2021 NCQA adult Medicaid national averages and the corresponding 2020 scores.[3-10, 3-11] Additionally, the overall member experience ratings (i.e., star ratings) resulting from HMSA QI's top-box scores compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-12]

Table 3-33—Adult Medicaid CAHPS Results for HMSA QI

Measure	2020 Scores	2022 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	57.6%	59.0%	★★
Rating of All Health Care	50.9%	56.8%	★★
Rating of Personal Doctor	61.3%	61.8%	★
Rating of Specialist Seen Most Often	60.4%	75.9% ▲	★★★★★
Composite Measures			
Getting Needed Care	75.1%	78.5%	★
Getting Care Quickly	75.2%	71.8%	★
How Well Doctors Communicate	92.7%	90.6%	★
Customer Service	79.8%	87.5%+	★★
Individual Item Measure			
Coordination of Care	81.0%	79.4%+	★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2021 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2021 NCQA adult Medicaid national averages.
▲ Indicates the 2022 score is statistically significantly higher than the 2020 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2020 score.

3-10 The adult population was last surveyed in 2020; therefore, the 2022 adult CAHPS scores are compared to the corresponding 2020 scores.
3-11 National Committee for Quality Assurance. *HEDIS® Measurement Year 2021, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2021.
3-12 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

Measure	2020 Scores	2022 Scores	Star Ratings
+ 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 HMSA QI's adult Medicaid population, the following one measure scored statistically significantly higher in 2022 than in 2020:

- *Rating of Specialist Seen Most Often*

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

- *Rating of Specialist Seen Most Often*

Areas for Improvement

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. HMSA QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-34 provides a summary of the key drivers identified for HMSA QI.

Table 3-34—HMSA QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Q4. Received care as soon as needed when care was needed right away	✓	✓	
Q9. Ease of getting the care, tests, or treatment needed		✓	
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers			✓

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

- Respondents reported not always receiving care as soon as they needed when care was needed right away.
- Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their plan.

The following observation from the key drivers of member experience analysis indicates an area 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.

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

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 five EQR activities. While the compliance monitoring review and network adequacy activities revealed that HMSA QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

HMSA QI showed that it has systems, policies, and staff in place to ensure that its structure and operations support core processes for providing care and services and promoting quality outcomes. HMSA QI's performance during the 2022 compliance review was above average, meeting or exceeding the statewide compliance score for seven of the eight standards. HMSA QI achieved 100 percent compliance in four standards and scored below the statewide average in only one standard. HMSA QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor HMSA QI's CAP activities until the health plan is found to be in full compliance.

HMSA QI maintained robust systems for updating, verifying, storing, and sharing provider network data in accordance with State expectations. HSAG's CY 2022 NAV findings suggest that HMSA QI's current provider network data systems and processes, as reported by the health plan in the PDSQ, are sufficient to support future NAV activities.

Overall, more than half (58.5 percent) of HMSA QI's performance measures fell below the 50th percentile across all domains. While some measures showed improvement from HEDIS MY 2020, HMSA QI's performance suggested several areas in need of improvement, including the Children's Preventive Health and Behavioral Health domains. While 11 of the MQD Quality Strategy targets were met in HEDIS MY 2021, HMSA QI should focus improvement efforts on Children's Preventive Health and Behavioral Health measures that fell below the 25th percentile.

HMSA QI's CAHPS results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower in 2022 than in 2020, the following eight

measures were below the 50th percentiles: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. Additionally, two of the nine measures scored statistically significantly lower than the 2021 NCQA adult Medicaid national averages: *Rating of Personal Doctor* and *Getting Care Quickly*. These results indicate the need for HMSA QI to implement improvement strategies to ensure members have high-quality care and timely access to care.

While none of the three measures the MQD selected for monitoring within its Quality Strategy met or exceeded the 75th percentiles, HMSA QI should focus improvement efforts on the measures that fell below the 25th percentile (*Getting Needed Care* and *How Well Doctors Communicate*).

Finally, HMSA QI progressed to the Design and Implementation stages of the two new PIP topics selected in CY 2022. The topics addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, HMSA QI received an overall *Met* validation status. The reported baseline data were not comprehensive, as they did not include all the trigger events and data sharing information with all the partnering agencies. The health plan is partnering with CCS and CAMHD to determine a workflow for ongoing communication and information sharing.

For the *Plan All-Cause Readmissions* PIP, HMSA QI received an overall *Met* validation status. The documented PIP design was accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. There were opportunities to improve the documentation of performance indicator data. The health plan will be assessed for improvement in outcomes in the next validation cycle.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

Compliance Monitoring Review

The 2022 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-35 presents the standards and compliance scores for KFHP QI.

Table 3-35—Standards and Compliance Scores—KFHP QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Availability of Services	17	17	15	2	0	0	94%
II	Assurances of Adequate Capacity and Services	3	3	0	3	0	0	50%
III	Coordination and Continuity of Care	10	10	9	1	0	0	95%
IV	Confidentiality	9	9	9	0	0	0	100%
V	Coverage and Authorization of Services	31	31	31	0	0	0	100%
VI	Enrollee Information	19	19	17	1	1	0	92%
VII	Enrollee Rights and Protections	8	8	7	1	0	0	94%
VIII	Grievance and Appeal System	31	31	30	1	0	0	98%
	Totals	**128**	**128**	**118**	**9**	**1**	**0**	**96%**

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

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

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

Strengths

KFHP QI was found to be 100 percent compliant with the Coverage and Authorization of Services standard. KFHP QI's policies and procedures met the requirements for providing and paying for emergency, urgent, and poststabilization services; for ensuring consistent application of UM criteria (by conducting interrater reliability reviews); and for providing the required covered array of Medicaid services. Through documented policies and procedures, KFHP QI provided evidence that it had the

appropriate mechanisms in place for receiving, reviewing, processing, and monitoring service authorization decisions for members and providers. A review of service denials demonstrated that the files were well organized and provided evidence that KFHP QI monitored its internal UM processes to ensure timeliness and consistency of authorization decisions. All decisions were made within the required time frames and by providers with the appropriate clinical expertise. The NABDs were written in a manner that was easily understood, at or below a sixth-grade reading level, and sent to the member and requesting provider.

The health plan was also fully compliant with the Confidentiality standard. KFHP QI demonstrated that it had in place policies and procedures that address the use and disclosure of PHI and PII. All newly hired staff members are required to receive privacy and confidentiality training at the time of hire and on an annual basis. KFHP QI had monitoring mechanisms that ensured PHI and PII were safeguarded and released only with a member's authorization and in alignment with applicable federal regulations.

KFPH QI also scored high in the Grievance and Appeal System standard, with 98 percent compliance and only one of the 31 elements scoring *Partially Met.* KFHP QI had well-defined policies, procedures, and systems for logging, tracking, and reporting member grievances and appeals. The health plan had several coordinators dedicated to the processing of grievances and appeals. A review of grievance and appeal files found that all cases were acknowledged and resolved within the required time frames and notifications to members were written in a manner and format that was easily understandable.

The health plan was found to be 95 percent compliant with the Coordination and Continuity of Care standard, with only one element scoring *Partially Met*. KFHP QI had comprehensive policies, procedures, and processes in place to deliver and coordinate the care of its members. KFHP QI demonstrated the implementation of its policies and procedures, and ability to coordinate the care of its members through a review of care coordination files. The files were well organized and provided evidence that members were involved in the development of the HAP, and health coordinators ensured that member privacy was protected during care coordination activities and that the HAP and any other relevant information was shared with the member's PCP and other involved providers. All HAPs were completed within 30 days of completion of the initial HFA. Members were provided the contact information of their assigned health coordinator and were also able to send messages directly to the health coordinator through KFHP QI's member portal.

Finally, KFHP QI showed high compliance in the Enrollee Rights and Protections and Enrollee Information standards. KFHP QI had member information and staff members available to help members understand the requirements and benefits of the plan. Upon enrollment, KFHP QI mailed newly enrolled members a welcome packet that included the member handbook and other pertinent information. KFHP QI maintained a member portal on its website for QI members, which contained information about the health plan, services provided, the provider network, and health plan contact information. KFHP QI had policies, procedures, and written member and provider information regarding member rights. The health plan, through training and education, ensured that staff members and providers were informed of member rights and responsibilities. Ongoing monitoring of complaints and grievances related to suspected rights violations occurred to ensure that staff members and providers adhered to and protected member rights.

Areas for Improvement

The greatest room for improvement for KFHP QI was within the Availability of Services and Assurances of Adequate Capacity and Services standards, with five elements found to be *Partially Met* among the two standards. KFHP QI had policies and procedures in place to monitor its network and ensure that all covered services were available and accessible to its members in a timely manner and met the standards developed by the State for network adequacy. While KFHP QI provided some anecdotal evidence regarding its network having sufficient family planning providers and LTSS providers who travel to members to deliver services, the health plan did not have any demonstrable evidence, such as reports or a monitoring dashboard, to show that its network was sufficient to meet the needs of its enrolled members. Additionally, KFHP QI was unable to provide assurance to the State that it had an adequate network to serve the expected enrollment in its service area. The corrective actions required by KFHP QI were to implement mechanisms to monitor its network and submit reports to the State to demonstrate the adequacy of its provider network.

Validation of Network Adequacy

Findings

Provider data structure: KFHP QI subcontracted with the Hawaii Permanente Medical Group (HPMG). HPMG collected and maintained provider information in a SAAS-based (Web-based) human resource and payroll system hosted by Ultimate Kronos Group (UKG), dba Ultimate Software. Monthly reports were pulled from UKG by HPMG Analytics to combine with operational data. KFHP QI used the Kaiser Permanente (KP) Claims Connect (Tapestry system) to link claims to the correct vendor, provider, and place of service records using matching logic such as tax ID and NPI. Together, these records drove various processes during auto adjudication, including contract selection and network selection. Electronically loaded claims used American National Standards Institute (ANSI) data, such as the provider's NPI, the vendor's NPI, or the vendor's tax ID to research and correct any matching errors identified. If a matching record could not be found, the system applied a pend code for no vendor, place of service, or provider, and the claim was sent to the appropriate team to resolve. When claims pended, the ANSI data were used to search for and build the records needed to resolve the claim.

Delegated services: KFHP QI reported delegating some services (i.e., contracting all or part of the provision of selected services, such as BH services) to another entity. Table 3-36 summarizes KFHP QI's delegated provider type/services, delegated entity names, and the frequency with which the health plan received provider data from the delegated entity at the time of the questionnaire response.

Table 3-36—KFHP QI Delegated Services

Provider Type/Service	Delegated Entity Name	Provider Data Frequency
Case management services	Community Care Management Agency	Forms were completed when there was a new KFHP QI member assessment.

Provider Type/Service	Delegated Entity Name	Provider Data Frequency
MD—Physician DO—Physician Osteopath Certified Nurse—Midwife Physician Assistant Podiatrist Board Certified Behavior Analyst Psychologist	Hawaii Permanente Medical Group	HPMG notified KFHP QI of changes in the network through monthly reports

KFHP QI provided multiple documents, including its Delegation Oversight Policies and Procedures documents supplemental to its PDSQ responses.

Provider classification data collection and maintenance: KFHP QI submitted information on selected provider categorization fields and supplied a corresponding data dictionary, as requested. Table 3-37 details all provider classifications in use by KFHP QI, as well as the mechanism for reporting and frequency of updating these classifications.

Table 3-37—KFHP QI Provider Classifications

Provider Classification	Reporting Mechanism	Update Frequency
Provider Type	Providers were classified into Primary Care and Specialty Care based on the providers' primary specialty. HPMG Provider Database (PDB)—physician, mid-level providers	As needed
Provider Specialty	Providers self-reported and verified by Credentialing department	As needed
Provider Taxonomy	Providers self-reported and verified by Credentialing department	As needed
Degree Attained (e.g., MD, RN, etc.)	Providers self-reported and verified by Credentialing department	As needed
Licenses and Certifications for Individuals and/or Facilities	Providers self-reported and verified by Credentialing department	Update frequency varied on the license and/or certification. HPMG human resources monitored expiration and reminded providers
Other: Employment Relationship	Providers were classified into Salaried Providers, ProTem Providers, and Agency Providers. PDB did not have employment relationship.	As needed

Provider indicators: HSAG asked each health plan to specify whether its provider data system included fields for the following provider indicators: PCP, Prenatal Care Providers, BH Providers, HCBS Providers, Active/Inactive Providers, Telehealth Providers, and SUD Providers, including those offering MAT. Table 3-38 details KFHP QI's reported responses and additional information regarding provider indicators.

Table 3-38—KFHP QI Provider Indicators

Provider Indicators	In Data System?	If Yes, Methods for Classifying Providers
PCPs	Yes	All providers with a provider specialty of Family Practice, Internal Medicine, Geriatrics, or Pediatrics.
Prenatal Care Providers	Yes	All providers with a Provider Specialty of OB/GYN, Primary Care, Certified Nurse-Midwife.
Behavioral Health Providers	Yes	All providers with a provider specialty of Integrated Behavioral Health (physicians only). PDB may include some therapists.
SUD Treatment Providers, including providers offering MAT	No	
HCBS Providers	No	
Active/Inactive Providers	Yes	Active and Inactive providers are reported on separate tabs on the data files.
Telehealth Providers	Yes	Providers who practice in the ambulatory setting offer telehealth services.

Providers accepting new patients: KFHP QI confirmed that its provider data system included fields to identify providers accepting new patients for all HPMG providers who were empaneled (i.e., primary care MDs and physician assistants).

Panel capacity: KFHP QI confirmed that its provider data system did not include fields to identify a provider's panel capacity.

Use of single case agreements: KFHP QI reported that SCAs were member-specific for a specific service and time frame, typically six months to a year.

KFHP QI reported that LOAs could be for a single members or could be blanket LOAs for multiple members, or at the discretion of KFHP QI's administration. Administration Discretions are unique to KFHP QI, where an LOA with a provider is executed for noncovered services. Executed LOAs were sent to KFHP QI's Claims division as part of the authorization and are attached to the member's record.

All SCAs and LOAs had a pend code (PRH08) in KFHP QI's claims system. Out-of-network LOAs were managed through HRGi, a third-party organization.

Provider network monitoring: KFHP QI monitored the adequacy of its provider network and members' ability to access the necessary services in accordance with Section 8.1 – Provider Network of the State of Hawaii Request for Proposal. In addition, KFHP QI used its PNA reporting to monitor the adequacy of its provider network.

Health plans' provider data verification and cleaning: Provider Contracting had a dedicated email for providers to share data changes. Additionally, KFHP QI was notified by the Claims department when claim addresses did not match the database. Credentials were validated by the KFHP QI Credentialing department and background checks upon contracting.

All changes to provider data in UKG were documented on a Personnel Action Notice. Data entry into UKG was then validated by multiple members of HPMG's HR and/or Payroll departments. Additionally, the Analytics department built error-checking algorithms into the daily data pull from UKG. Credentials were validated by the KP Credentialing department and HPMG contracted background checks upon hire. The provider database went through monthly updates via mining from credentialing or if a provider informed KFHP QI of needed updates.

Communicating provider network information to members: KFHP QI uploaded provider directories to KFHP QI's public website each month. From the website, members were able to access provider information in the Health Maintenance Organization, LTSS, or Community Integration Services (CIS) provider directories. members were also able to access provider information through the KFHP QI member portal. Members could call to schedule appointments or speak to Customer Service for more information.

Strengths

KFHP QI maintained detailed data regarding provider classifications (e.g., provider type, specialty, network participation, etc.) and reported multiple methods for updating, verifying, and cleaning provider data. KFHP QI also used multiple methods for monitoring its provider network and communicating provider network information to members.

Areas for Improvement

KFHP QI did not maintain data fields to identify SUD treatment providers or HCBS providers. Additionally, KFHP QI did not collect data regarding provider panel capacity and did not monitor new patient acceptance for all provider types.

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 three standard and one nonstandard supplemental data sources to review for MY 2021 reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2021 performance measure reporting.

KFHP QI was required to undergo convenience sample validation for the *Prenatal and Postpartum Care* and *Cervical Cancer Screening* measures. All cases successfully passed the validation process. The final MRRV was conducted for the *Comprehensive Diabetes Care—Blood Pressure Control <140/90* and *Eye Exam* indicators, as well as for the *Controlling High Blood Pressure* measure. All selected records passed the validation process without any critical issues. 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 denominators were 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 3-39. The one rate in this domain that could be compared to national benchmarks ranked at or above the 90th percentile. All three rates for the non-HEDIS *Heart Failure Admission Rate* measure demonstrated a relative decline (i.e., improvement). Of note, the ages 65 and older rate improved by more than 15 percent. One measure in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total*), and KFHP QI met or exceeded the established target for HEDIS MY 2021.

Table 3-39—KFHP QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Heart Failure Admission Rate*				
18-64 Years	37.73	36.75	-2.60%	NC
65+ Years	107.76	88.05	-18.29%	NC
Total	42.72	40.56	-5.06%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	8.15%	7.56%	-7.24%	★★★★★
Expected Readmissions—Total	9.98%	9.85%	-1.30%	NC
*Index Total Stays—O/E Ratio—Total**	0.82	0.77	-6.37%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-40. Overall, KFHP QI demonstrated a relative decline for all but five rates in this domain. Of note, eight of the *Childhood Immunization Status* rates ranked at or above the 50th percentile, four of which ranked at or above the 90th percentile. Additionally, KFHP met or exceeded the MQD's established Quality Strategy targets for HEDIS MY 2021 for three measure rates in this domain (*Child and Adolescent Well-Care Visits—Total, Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits,* and *Childhood Immunization Status—Combination 3*).

Table 3-40—KFHP QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Child and Adolescent Well-Care Visits				
3–11 Years	43.43%	41.63%	-4.14%	★
12–17 Years	34.36%	42.49%	23.66%	★★
18–21 Years	11.28%	12.84%	13.83%	★
Total	35.54%	36.94%	3.94%	★
Childhood Immunization Status				
Combination 2	82.50%	74.44%	-9.77%	NC
Combination 3	80.42%	72.10%	-10.35%	★★★
Combination 4	80.42%	72.10%	-10.35%	NC
Combination 5	74.31%	69.86%	-5.99%	NC
Combination 6	68.89%	62.73%	-8.94%	NC
Combination 7	74.31%	69.86%	-5.99%	★★★★★
Combination 8	68.89%	62.73%	-8.94%	NC
Combination 9	63.75%	60.81%	-4.61%	NC
Combination 10	63.75%	60.81%	-4.61%	★★★★★
DTaP	84.58%	75.93%	-10.23%	★★★
Hepatitis A	90.42%	85.30%	-5.66%	★★★
Hepatitis B	91.25%	90.31%	-1.03%	★★★
HiB	88.19%	79.98%	-9.31%	★
Influenza	74.72%	72.10%	-3.51%	★★★★★
IPV	91.39%	88.07%	-3.63%	★★
MMR	91.25%	85.09%	-6.75%	★
Pneumococcal Conjugate	82.64%	73.06%	-11.59%	★★

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Rotavirus	81.94%	84.45%	3.06%	★★★★★
VZV	90.56%	85.20%	-5.92%	★★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	68.91%	73.09%	6.07%	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	84.62%	80.51%	-4.86%	★★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-41. 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. Additionally, all three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2021, and KFHP QI met or exceeded all three of the established MQD Quality Strategy targets.

Table 3-41—KFHP QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Cervical Cancer Screening				
Cervical Cancer Screening	74.90%	67.36%	-10.07%	★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	93.60%	89.62%	-4.25%	★★★★
Postpartum Care	83.60%	84.62%	1.22%	★★★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
[1] MY 2021 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 3-42. The six measure rates that could be compared to national benchmarks ranked at or above the 50th percentile, two of which met or exceeded the 75th percentile and two of which met or exceeded the 90th percentile. Two of the *Comprehensive Diabetes Care* rates in this domain reported a relative decrease of more than 5 percent, and two rates demonstrated a relative increase of more than 5 percent. The *Concurrent Use of Opioids and Benzodiazepines—18–64 Years* and *Total* rates showed a relative decline (i.e., improved performance). Conversely, the rate for *65+ Years* showed a relative increase, indicating a decline in performance for this measure. Six measure rates within this domain were associated with an MQD Quality Strategy target for HEDIS MY 2021, and KFHP QI met or exceeded the established targets for four of these measure rates.

Table 3-42—KFHP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Comprehensive Diabetes Care				
HbA1c Testing	86.88%	90.95%	4.68%	★★★★★
*HbA1c Poor Control (>9.0%)**	41.05%	35.64%	-13.18%	★★★★
HbA1c Control (<8.0%)	49.04%	52.64%	7.34%	★★★★
Eye Exam (Retinal) Performed	58.42%	55.12%	-5.65%	★★★
Blood Pressure Control (<140/90 mm Hg)	57.14%	64.15%	12.27%	★★★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	8.44%	6.75%	-20.02%	NC
65+ Years	2.94%	9.09%	209.18%	NC
Total	7.63%	7.11%	-6.82%	NC
Controlling High Blood Pressure				
18-64 Years	—	64.86%	—	NC
65-85 Years	—	73.00%	—	NC
Total (18-85 Years)	—	67.02%	—	★★★★★

** A lower rate indicates better performance.*
Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-43. The *Screening for Depression and Follow-Up Plan—12–17 Years* rate showed a relative decline of more than 17 percent, and the remaining age groups showed a relative decline of more than 30 percent. The *Use of Pharmacotherapy for Opioid Use Disorder—Total, Buprenorphine,* and *Oral Naltrexone* rates demonstrated a relative increase and met the MQD's established Quality Strategy targets. Conversely, the *Methadone* rate showed a 100 percent decline in performance. Of the measures that could be compared to national benchmarks, four measure rates ranked at or above the 50th percentile and four measure rates fell below the 25th percentile. KFHP QI met or exceeded the MQD's established Quality Strategy targets for six measure rates within this domain.

Table 3-43—KFHP QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	38.54%	45.04%	16.87%	★★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	43.70%	49.69%	13.71%	★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	55.21%	63.36%	14.76%	★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	58.82%	67.70%	15.10%	★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation—Total—13–17 Years	—	NA	—	NC
Initiation—Total—18+ Years	—	37.48%	—	★
Initiation—Total—Total	—	37.18%	—	★
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18+ Years	—	8.15%	—	★
Engagement—Total—Total	—	7.83%	—	★
Screening for Depression and Follow-Up Plan				
12–17 Years	2.07%	1.70%	-17.87%	NC
18–64 Years	10.89%	7.56%	-30.58%	NC
65 Years and Older	13.79%	9.16%	-33.58%	NC
18 Years and Older	11.14%	7.71%	-30.79%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	44.21%	62.16%	40.60%	NC
Buprenorphine	33.68%	59.46%	76.54%	NC
Oral Naltrexone	1.05%	2.70%	157.14%	NC

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Long-Acting, Injectable Naltrexone	0.00%	0.00%	—	NC
Methadone	13.68%	0.00%	-100.00%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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*

Long-Term Services and Supports Performance Measure Results

KFHP QI's Long-Term Services and Supports performance measure results are shown in Table 3-44. MY 2021 represented the first year for reporting the measures in this domain; therefore, no prior years' rates are presented. In addition, the measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established. All measures in this domain were determined to be *Reportable*; however, for the *LTSS Minimizing Institutional Length of Stay* measure rates, KFHP QI did not have enough members in its eligible population to report valid rates; therefore, a status of *NA* (i.e., small denominator) was assigned.

Table 3-44—KFHP QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level
LTSS Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	—	10.11%	—	NC
Care plan with Supplemental Elements Documented	—	10.11%	—	NC
LTSS Minimizing Institutional Length of Stay				
Observed Discharge Rate	—	NA	—	NC
Expected Discharge Rate	—	NA	—	NC
Observed/Expected Ratio	—	NA	—	NC
LTSS Shared Care Plan with Primary Care Practitioner				
Shared Care Plan with Primary Care Practitioner	—	73.68%	—	NC

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.

Conclusions and Recommendations

Based on HSAG's analyses of KFHP QI's 37 measure rates comparable to benchmarks, 24 measure rates (64.9 percent) ranked at or above the 50th percentile, with eight rates (21.6 percent) meeting or exceeding the 75th percentile and nine rates (24.3 percent) meeting or exceeding the 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met 17 of the MQD Quality Strategy targets for HEDIS MY 2021.

Conversely, 13 of KFHP QI's measure rates comparable to benchmarks (35.1 percent) fell below the 50th percentile, nine of which (24.3 percent) fell below the 25th 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 25th percentile for the QI population:

- Children's Preventive Health
  - *Child and Adolescent Well-Care Visits—3–11 Years, 18–21 Years,* and *Total*
  - *Childhood Immunization Status—HiB* and *MMR*
- Behavioral Health
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—18+ Years, Initiation—Total, Engagement—Total—18+ Years,* and *Engagement—Total—Total*
  - *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

Validation of Performance Improvement Projects

In CY 2022, the MQD selected two new PIPs—*Behavioral Health Coordination* and *Plan All-Cause Readmissions* for all the health plans to complete. For the CY 2022 submission, the health plans progressed to the Design and Implementation stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The health plan will be assessed for improvement in outcomes (Step 9) in the next validation cycle.

Table 3-45 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-45—CY 2022 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design and Implementation Stage (Steps 1 through 8)	07/01/2021 to 09/30/2021	Baseline

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Plan All-Cause Readmissions	PIP Design and Implementation Stage (Steps 1 through 8)	CY 2021	Baseline

The focus of the nonclinical *Behavioral Health Coordination* (BH) PIP is to integrate care between the DOH Behavioral Health Services Administration divisions, CCS, and the QI Health Plans. This includes developing an infrastructure to streamline communication, information sharing, and continuity and coordination of care across agencies that provide services for a population with severe persistent mental illness, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by the MQD in consultation with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG.

The focus of the clinical *Plan All-Cause Readmissions* PIP is to decrease unplanned member readmission rates. The performance indicator for this PIP is based on the HEDIS *PCR* measure.

Findings

Table 3-46 illustrates the validation results for the two PIPs submitted by KFHP QI for CY 2022 validation.

Table 3-46—CY 2022 PIP Validation Results for KFHP QI

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	100%	100%	*Met*
Plan All-Cause Readmissions	100%	100%	*Met*

For both PIPs, KFHP QI received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 100 percent for overall evaluation elements across all steps completed and validated.

Design (Steps 1-6)

Behavioral Health Coordination

KFHP QI met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD. The MQD held workgroup meetings with health plans, DOH Behavioral Health Services Administration divisions, and HSAG to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the

workgroup sessions. KFHP QI documented the PIP design accurately and as discussed during the workgroup meetings. KFHP QI's data collection process as documented appeared methodologically sound; however, the data collection process was not comprehensive at the time of the PIP submission. KFHP QI was in the process of defining its processes to capture the denominator data for all the trigger events identified in Indicator 1. Additionally, the data sharing processes with the DOH Behavioral Health Services Administration divisions were to be determined.

Plan All-Cause Readmissions

KFHP QI met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. KFHP QI's Aim statement set the focus of the PIP and the framework for data collection and analysis of results. KFHP QI clearly defined the eligible population and the performance indicator, which aligned with the HEDIS specifications. KFHP QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

KFHP QI reported the baseline rates as available for the two performance indicators. KFHP QI documented its quality improvement efforts toward implementing the MQD-mandated interventions for this PIP. KFHP QI also documented that it is participating in regular workgroup meetings with partnering agencies to define accountabilities, identify needed workflows for a standard structure for information sharing to occur, provide further clarity on measure indicators as issues arise, and bring order to the complexities of other workflows involved in coordination and communication.

Plan All-Cause Readmissions

KFHP QI accurately reported the baseline numerator, denominator, and percentage rate for the performance indicator. KFHP QI conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes.

Analysis of Results

Table 3-47 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-47—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. Percent of shared members with eligible trigger events who received	N: 5	3.4%		

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
a combined review in the past three months.	D: 149			
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 9 D: 223	4.0%		

N–Numerator D–Denominator

The rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 3.4 percent. Out of the 149 members with eligible trigger events, four combined reviews were for members shared with CCS and one for a member shared with CAMHD of the Hawaii DOH. The health plan also noted that a few of the trigger events, including incarceration, care transitions, a child who opts out of receiving health services, and shared members with challenging or breakthrough behavioral issues and substance use disorder, do not have identifiable data to easily produce a report at the time of PIP submission.

The baseline rate for the percentage of shared members whose data were actively shared with the partner agencies during the measurement period was 4.0 percent.

For both the indicators, the data included was for shared members with CCS and CAMHD only. The mechanisms for sharing data with other DOH agencies were in the process of being researched and developed by the health plan.

Table 3-48 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-48—Performance Improvement Project Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. For members 18–64 years old, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	N: 59 D: 780	7.6%		

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one unplanned acute readmission for any diagnosis within 30 days of the Index

Discharge Date was 7.6 percent. The health plan will be assessed for statistically significant improvement in the performance indicator rate in the next annual submission.

Barriers/Interventions

A health plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions documented by the health plans for appropriateness to the barriers identified and the timeliness of the implementation of the interventions.

Table 3-49 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-49—Interventions Implemented/Planned for KFHP QI PIPs

PIP Topic	Barriers	Interventions
Behavioral Health Coordination	1. Little or no systematic data sharing. 2. Lack of communication, ambiguous accountability. 3. Lack of workflows.	1. Drafting and executing MOUs with the partnering agencies regarding data sharing.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*
Plan All-Cause Readmissions	1. Inconsistent patient engagement. 2. Location of Transitional Care Center (TCC) clinic. 3. Health coordinator assignment.	1. Road shows and training of patient care coordinators and hospitalists to educate members on and promote the benefits of the services offered at the TCC. 2. Offer TCC clinic one day a week at West Oahu medical offices. 3. Assign a health coordinator to any members discharged with readmission risk score of ≥23.

* The documented interventions are required by the MQD.

Strengths

- For both PIPs, KFHP QI received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- For the *Behavioral Health Coordination* PIP, the health plan had initiated collaborative discussions with the partnering agencies for data sharing and combined reviews.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the reported data for the two performance indicators were incomplete and were for shared members with CCS and CAMHD only. The health plan should work toward improving its data capturing and sharing capabilities with all the partnering agencies and in accordance with the PIP specifications.

- For the *Plan All-Cause Readmissions* PIP, the health plan should initiate interventions identified by the Readmissions Collaborative workgroup.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- The health plan should continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP:
  - The health plan should document its progress toward implementing the interventions and expanding the data sharing efforts with all the partnering agencies.
  - The baseline data for the performance indicators should be updated as the health plan determines the information sharing and data collection processes for all the trigger events and with all the partnering agencies.
  - The health plan should capture any informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more rich information as part of this PIP for long-term care coordination needs.
  - The health plan should update Step 3 and Step 5 of the PIP Submission Form with any changes made to the performance indicator specifications; for example, any changes to the combined review trigger events that were approved by the MQD should be updated in the next annual submission.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan should document the barriers, interventions, and quality improvement activities undertaken as part of the Readmissions Collaborative workgroup to improve the *PCR* rate.
- The health plan should continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- The health plan should have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- The health plan must address the validation feedback associated with any *Met* score in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and the MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-50 presents the 2022 percentage of top-box responses (i.e., top-box scores) for KFHP QI compared to the 2021 NCQA adult Medicaid national averages and the corresponding 2020 scores.[3-13, 3-14] Additionally, the overall member experience ratings (i.e., star ratings) resulting from KFHP QI's top-box scores compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-15]

Table 3-50—Adult Medicaid CAHPS Results for KFHP QI

Measure	2020 Scores	2022 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	69.8%	62.9% ▼	★★★
Rating of All Health Care	67.5%	60.9%	★★★
Rating of Personal Doctor	73.5%	64.1% ▼	★
Rating of Specialist Seen Most Often	75.5%	62.9% ▼	★
Composite Measures			
Getting Needed Care	86.2%	79.6% ▼	★
Getting Care Quickly	82.5%	78.9%	★
How Well Doctors Communicate	96.6%	90.6% ▼	★
Customer Service	90.9%	85.1%+	★
Individual Item Measure			
Coordination of Care	94.8%	79.2% ▼	★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2021 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2021 NCQA adult Medicaid national averages.

▲ Indicates the 2022 score is statistically significantly higher than the 2020 score.

▼ Indicates the 2022 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

[3-13] The adult population was last surveyed in 2020; therefore, the 2022 adult CAHPS scores are compared to the corresponding 2020 scores.

[3-14] National Committee for Quality Assurance. *HEDIS® Measurement Year 2021, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2021.

[3-15] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

Strengths

None of the 2022 top-box scores were statistically significantly higher than the 2021 NCQA adult Medicaid national averages or 2020 top-box scores for any measure; therefore, no substantial strengths were identified.

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 3-51 provides a summary of the key drivers identified for KFHP QI.

Table 3-51—KFHP QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	✓	✓	✓

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

- Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their plan.

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

- Respondents reported their personal doctor did not always seem informed and up-to-date about the care they received from other doctors or health providers.

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

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 five EQR activities. While the compliance monitoring review activity revealed that KFHP QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on some outcome and process measures showed a decline from high performance in previous years.

KFHP QI showed that it has 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. KFHP QI's performance during the 2022 compliance review was average, meeting or exceeding the statewide compliance score for five of the eight standards. KFHP QI achieved 100 percent compliance in two standards and scored at or above the statewide average in three other standards. KFHP QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor KFHP QI's CAP activities until the health plan is found to be in full compliance.

KFHPQ QI maintained robust systems for updating, verifying, storing, and sharing provider network data in accordance with State expectations. HSAG's CY 2022 NAV findings suggest that Kaiser's current provider network data systems and processes, as reported by the health plan in the PDSQ, could be improved with the addition of identifiers for SUD and HCBS providers.

KFHP QI continued to show strong performance in quality, performance, and outcome measures. Overall, more than half (64.9 percent) of KFHP QI's measure rates ranked at or above the 50th percentile across all domains, with nearly one quarter (24.3 percent) of the measure rates ranking at or above the 75th percentile. Conversely, 13 of KFHP QI's measure rates (35.1 percent) fell below the 50th percentile. KFHP QI's performance demonstrated a few areas for improvement, including the Children's Preventive Health and Behavioral Health domains. KFHP QI's measure rates met 17 of the MQD Quality Strategy targets.

KFHP QI's CAHPS results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower than the 2021 NCQA adult Medicaid national averages, the following seven measures were below the 50th percentiles: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. Additionally, the following six measures scored statistically significantly lower in 2022 than in 2020: *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Coordination of Care*. These results indicate the need for KFHP QI to implement improvement strategies to ensure that members have high-quality care and timely access to care.

While none of the three measures the MQD selected for monitoring within its Quality Strategy met or exceeded the 75th percentiles, KFHP QI should focus improvement efforts on the measures that fell below the 25th percentile (*Getting Needed Care* and *How Well Doctors Communicate*).

Finally, KFHP QI progressed to the Design and Implementation stages of the two new PIP topics selected in CY 2022. The topics addressed CMS' requirements related to quality outcomes—

specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, KFHP QI received an overall *Met* validation status. The reported baseline data were not comprehensive, as they did not include all the trigger events and data sharing information with all the partnering agencies.

For the *Plan All-Cause Readmissions* PIP, KFHP QI received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The health plan will be assessed for improvement in outcomes in the next validation cycle.

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

Compliance Monitoring Review

The 2022 compliance monitoring review activity included evaluation of the health plan’s compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-52 presents the standards and compliance scores for ‘Ohana QI.

Table 3-52—Standards and Compliance Scores—‘Ohana QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Availability of Services	17	17	16	1	0	0	97%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	0	100%
III	Coordination and Continuity of Care	10	10	8	2	0	0	90%
IV	Confidentiality	9	9	9	0	0	0	100%
V	Coverage and Authorization of Services	31	31	24	7	0	0	89%
VI	Enrollee Information	19	19	14	4	1	0	84%
VII	Enrollee Rights and Protections	8	8	7	1	0	0	94%
VIII	Grievance and Appeal System	31	31	31	0	0	0	100%
	Totals	**128**	**128**	**112**	**15**	**1**	**0**	**93%**

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

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

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

Strengths

‘Ohana QI was found to be 100 percent compliant with the Grievance and Appeal System standard. ‘Ohana QI had comprehensive policies, procedures, and systems for logging, tracking, and reporting member grievances and appeals, and the health plan maintained several staff members responsible for the processing of grievances and appeals. A review of grievance and appeal files found that all cases

were acknowledged and resolved within the required time frames, and notifications to members were written in a manner and format that was easily understandable.

The health plan also scored 100 percent compliance in the Confidentiality standard. ‘Ohana QI demonstrated that it had in place policies and procedures that address the use and disclosure of PHI and PII. All newly hired staff members are required to receive privacy and security training at the time of hire and on an annual basis. In an effort to ensure continued compliance with and adherence to ‘Ohana QI’s privacy, security, and confidentiality policies, oversight of computer and electronic mail systems, monthly customer service call center staff audits, and other routine reporting and monitoring efforts were conducted.

‘Ohana QI showed high performance in the Availability of Services and Assurances of Adequate Capacity and Services standards, scoring 97 percent and 100 percent compliance, respectively. ‘Ohana QI had policies and procedures in place to monitor its network and ensure that all covered services were available and accessible to its members in a timely manner and met the standards developed by the State for network adequacy. Services included in the contract were made available to members 24 hours a day, seven days a week, when medically necessary. ‘Ohana QI conducted ongoing monitoring of its network, which included the review of various monitoring reports, including GeoAccess reports, for any significant provider changes or losses, evaluation of specialist ratios, and a review of any provider gaps.

Finally, ‘Ohana QI showed high compliance in the Enrollee Rights and Protections standard, with only one element scoring *Partially Met*. ‘Ohana QI maintained policies, procedures, and written member and provider information regarding member rights. ‘Ohana QI ensured protection of member rights through the provision of education and training of staff members and providers, and monitoring call center staff members to evaluate adherence to member rights policies. ‘Ohana QI also reviewed member grievances related to violations of rights, which provided a chance to identify opportunities for enhanced training of staff and/or providers on member rights.

Areas for Improvement

‘Ohana QI was found to be 90 percent compliant with the Coordination and Continuity of Care standard, with two of the 10 elements scoring *Partially Met.* ‘Ohana QI had comprehensive policies, procedures, processes, and staff in place to deliver and coordinate the care of its members. ‘Ohana QI demonstrated the implementation of its policies and procedures, and ability to coordinate the care of its members through a review of 10 randomly selected care coordination files. All HFAs were completed within 15 days of SHCN identification. The files provided evidence that members were involved in the development of the HAP, however HAPs were not always completed within the 30-day time frame nor shared with providers involved in the member’s care. The corrective actions required by ‘Ohana QI were to implement procedures to ensure HAPs were completed within the required time frame and that they were being sent to the member’s PCP or other involved providers.

The Coverage and Authorization of Services standard was also found to be an area for improvement, with seven elements scoring *Partially Met*. While ‘Ohana QI had policies, procedures, and program descriptions that provided evidence that it had mechanisms in place for receiving, reviewing, processing,

and monitoring service authorization decisions for members and providers, incorrect and inconsistent information was found among the various documents. Additionally, processes for ensuring readability of member notification letters were implemented inconsistently among staff members, and service termination procedures were not compliant with federal regulations. ‘Ohana QI was required to complete corrective actions to address the deficiencies in this standard.

Finally, ‘Ohana QI was found to be 84 percent compliant with the Enrollee Information standard, with four elements scoring *Partially Met* and one element scoring *Not Met.* In general, ‘Ohana QI had member information, customer service staff members, and service coordinators available to help members understand the requirements and benefits of the plan. The corrective actions required by ‘Ohana QI were related to updates needed to the member portal, updates to policies and procedures in the event of a provider termination, updates to the member handbook to ensure that it included information about the specific locations for emergency settings, and updates to the provider directory to include specific details regarding providers’ office accommodations for people with physical disabilities and ensure a machine-readable version was accessible on the health plan’s website.

Validation of Network Adequacy

Findings

Provider data structure: ‘Ohana QI reported that its provider data structure included Salesforce, iCertis, Intelligent Business Process Management Software (iBPS) provider load forms (PLFs), and Xcelys software. Provider information was entered into Salesforce, which housed the provider’s demographics, documentation of health plan outreach to the provider, and documents needed for credentialing. iCertis was the health plan’s contract management system through which ‘Ohana QI created, managed, and executed contracts. iBPS was ‘Ohana QI’s provider data management system that took the information received from providers and transferred it into the core processing system, Xcelys. Information obtained from the providers was transcribed into the PLF in preparation for provider load submission into Xcelys. Xcelys was where provider data were loaded and claims were processed. The provider’s information was loaded under a unique provider identification number tied to each individual or facility. Xcelys housed ‘Ohana QI’s provider data, which were linked to claims processing and contract reimbursement.

Delegated services: ‘Ohana QI reported delegating some services (i.e., contracting all or part of the provision of selected services, such as BH services) to another entity. Table 3-53 summarizes ‘Ohana QI’s delegated provider type/services, delegated entity names, and the frequency with which the health plan received provider data from the delegated entity at the time of the questionnaire response.

Table 3-53—‘Ohana QI Delegated Services

Provider Type/Service	Delegated Entity Name	Provider Data Frequency
Non-emergent transportation	IntelliRide	Quarterly

Provider Type/Service	Delegated Entity Name	Provider Data Frequency
Pharmacy benefit services	CVS	Daily via claims received
Vision services	Premier Eye Care	Monthly rosters were received with provider added, termed, and in network
Audiology services	HearUSA	Rosters presented to health plan on monthly calls with HearUSA
PCP/specialist within Hawaii Pacific Health Provider Network	Hawaii Pacific Health (HPH)	As HPH identified providers added to its network, its representative would send ‘Ohana QI’s Provider Data Management Team an updated spreadsheet
Community case management agencies	Above and Beyond Case Management Absolute Care Management Services Blue Water Resources Case Management Professionals Hale Makua Home Health Agency HI Secure Care Case Management Kinaole Case Management Lokahi Case Management Quality Case Management Residential Choices	Annually

Provider classification data collection and maintenance: ‘Ohana QI submitted information on selected provider categorization fields and supplied a corresponding data dictionary, as requested. Table 3-54 details all provider classifications in use by ‘Ohana QI, as well as the mechanism for reporting and frequency of updating these classifications.

Table 3-54—‘Ohana QI Provider Classifications

Provider Classification	Reporting Mechanism	Update Frequency
Provider Type	Received from State	State sent to the health plan monthly via file transfer protocol (FTP) file drop, which was processed into the system and updated into ‘Ohana QI’s PMR back-end database.
Provider Specialty	Provider self-reported	Provider is required to update or confirm information every three years from credentialing date
Provider Taxonomy	Provider self-reported and health plan validated from National Plan and Provider Enumeration System (NPPES)	Provider is required to update or confirm information every three years from credentialing date

Provider Classification	Reporting Mechanism	Update Frequency
Degree Attained (e.g., MD, RN, etc.)	Provider self-reported and health plan validated from Department of Commerce and Consumer Affairs (DCCA) Professional Vocational Licensing	Provider is required to update or confirm information every three years from credentialing date
Licenses and Certifications for Individuals and/or Facilities	Provider self-reported and health plan validated from DCCA Professional Vocational Licensing	Provider is required to update or confirm information every three years from credentialing date

Provider indicators: HSAG asked each health plan to specify whether its provider data system included fields for the following provider indicators: PCP, Prenatal Care Providers, BH Providers, HCBS Providers, Active/Inactive Providers, Telehealth Providers, and SUD Providers, including those offering MAT. Table 3-55 details 'Ohana QI's reported responses and additional information regarding provider indicators.

Table 3-55—'Ohana QI Provider Indicators

Provider Indicators	In Data System?	If Yes, Methods for Classifying Providers
PCPs	Yes	All providers with a provider specialty of, but not limited to, Family Practice, Internal Medicine, Geriatrics, Pediatrics, or APRN.
Prenatal Care Providers	Yes	All providers with a provider specialty of but not limited to OB/GYN or Certified Midwife.
Behavioral Health Providers	Yes	All providers with a provider specialty of Psychologist, Psychiatrist, BH Advanced Practice Registered Nurse (APRN-Rx), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Licensed Mental Health Counselor (LMHC).
SUD Treatment Providers, including providers offering MAT	Yes	All providers with a provider specialty of Substance Abuse or Behavioral Health Facility.
HCBS Providers	Yes	All providers with a provider specialty of, but not limited to, Adult Foster Care Home, Adult Day Care Center, Home Health Agency, Home Care Agency, Private Duty Nursing.
Active/Inactive Providers	Yes	In Xcelys claims processing software, these providers are listed as active if they are participating in network and active in claims submission.
Telehealth Providers	Yes	In Xcelys claims processing software, these providers are listed under the Telemedicine field.

Providers accepting new patients: 'Ohana QI confirmed that its provider data system included fields to identify providers accepting new patients for all provider types and specialties.

Panel capacity: ‘Ohana QI confirmed that its provider data system did not include fields to identify a provider’s panel capacity.

Use of single case agreements: ‘Ohana QI reported that SCAs are agreements made with participating providers who require enhanced rates on case-by-case bases (e.g. adult foster care homes, durable medical equipment (DME), and these agreements are also made with nonparticipating providers, such as out-of-state providers who service ‘Ohana QI’s Medicaid population based on a negotiated rate per case. These agreements are created per approved authorization for services and pertain to only one member at a time. The period during which these agreements are valid is usually the length of time approved under the authorization. SCAs were tracked and monitored via ‘Ohana QI’s internal SharePoint request system.

Provider network monitoring: ‘Ohana QI monitored the adequacy of its provider network on a quarterly basis and reported to the State per the established contract standards for time, distance, and minimum provider criteria. ‘Ohana QI used GeoAccess reports and Quest Analytics software for all adequacy analysis and mapping of providers.

Health plans’ provider data verification and cleaning: ‘Ohana QI validated provider information through Veda, which conducted quarterly reviews. A quarterly report was received via email from the Provider Network team with underlying data from Veda’s quarterly reviews. ‘Ohana QI reviewed providers’ past submissions to validate the data provided. If there was nothing on file, ‘Ohana QI would conduct an outbound call to providers to validate, and if the information on file was correct, the next step was to submit a request to the Provider Network team to ask that the information be unsuppressed. If action was required, ‘Ohana QI would submit a PLF to have the provider information updated in Xcelys.

Communicating provider network information to members: Provider information for ‘Ohana QI was shared with Medicaid members via the Find a Provider tool on ‘Ohana QI’s website, or the online provider directory. Members were also able to request a hard copy of the provider directory via ‘Ohana QI customer service representatives.

Strengths

‘Ohana QI maintained detailed data regarding provider classifications (e.g., provider type, specialty, network participation, etc.) and provider indicators (e.g., PCP, SUD treatment providers, prenatal care providers) and reported multiple methods for updating, verifying, and cleaning provider data. ‘Ohana QI also used multiple methods for monitoring its provider network and communicating provider network information to members and maintained data regarding new patient acceptance for all provider types and specialties.

Areas for Improvement

‘Ohana QI did not collect data regarding provider panel capacity for any provider types or specialties.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team validated 'Ohana QI's IS capabilities for accurate HEDIS reporting. 'Ohana QI was found to be fully compliant with all 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 five standard and two nonstandard supplemental data sources for MY 2021 reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2021 reporting.

'Ohana QI was required to undergo convenience sample validation for the *Controlling High Blood Pressure* and *Cervical Cancer Screening* measures. All cases successfully passed the validation process. The final MRRV was conducted for the *Controlling High Blood Pressure, Prenatal and Postpartum Care—Timeliness of Prenatal Care, Comprehensive Diabetes Care—HbA1c Control (<8.0%),* and *Childhood Immunization Status—Combination 7* measures. All records passed the validation without any critical issues.

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 denominators were 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 3-56. The one rate in this domain that could be compared to national benchmarks ranked at or above the 50th percentile. The non-HEDIS *Heart Failure Admission Rate—65+ Years* measure rate demonstrated a relative decrease in performance, with two of the three rates demonstrating more than a 5 percent increase, representing a decline in performance since lower rates for this measure indicate better performance. One measure in this domain had an MQD Quality Strategy target *Heart Failure Admission Rate—Total*), and 'Ohana QI did not reach the established target for HEDIS MY 2021.

Table 3-56—'Ohana QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Heart Failure Admission Rate*				
18-64 Years	80.25	91.62	14.17%	NC

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
65+ Years	177.64	155.76	-12.32%	NC
Total	97.31	102.84	5.68%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	10.54%	9.61%	-8.82%	★★★
Expected Readmissions—Total	11.62%	11.65%	0.26%	NC
*Index Total Stays—O/E Ratio—Total**	0.91	0.83	-9.33%	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.
[1] MY 2021 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 3-57. All *Childhood Immunization Status* rates demonstrated a relative decrease in performance, 14 of which reported a relative decrease of more than 15 percent. Only one of the *Childhood Immunization Status* rates (*Influenza)* ranked at or above the 50th percentile. Conversely, 11 rates fell below the 25th percentile. Of note, 'Ohana QI met the established MQD Quality Strategy target for the *Child and Adolescent Well-Care Visits—Total* measure rate.

Table 3-57—'Ohana QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Child and Adolescent Well-Care Visits				
3–11 Years	41.46%	45.60%	9.99%	★★
12–17 Years	38.11%	39.77%	4.36%	★★
18–21 Years	16.53%	16.76%	1.39%	★
Total	36.69%	39.15%	6.70%	★
Childhood Immunization Status				
Combination 2	63.78%	50.36%	-21.04%	NC
Combination 3	61.86%	48.66%	-21.34%	★
Combination 4	60.90%	48.42%	-20.49%	NC
Combination 5	54.49%	42.34%	-22.30%	NC
Combination 6	48.72%	40.39%	-17.10%	NC

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Combination 7	53.53%	42.09%	-21.37%	★
Combination 8	48.40%	40.15%	-17.05%	NC
Combination 9	43.91%	36.25%	-17.44%	NC
Combination 10	43.59%	36.01%	-17.39%	★★
DTaP	66.03%	51.82%	-21.52%	★
Hepatitis A	76.92%	63.99%	-16.81%	★
Hepatitis B	76.92%	69.10%	-10.17%	★
HiB	77.56%	66.18%	-14.67%	★
Influenza	56.41%	51.58%	-8.56%	★★★
IPV	78.21%	68.86%	-11.95%	★
MMR	78.53%	65.21%	-16.96%	★
Pneumococcal Conjugate	64.74%	52.55%	-18.83%	★
Rotavirus	63.14%	55.23%	-12.53%	★
VZV	78.85%	65.21%	-17.30%	★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	58.58%	51.86%	-11.47%	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	66.38%	59.82%	-9.88%	★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-58. 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. Of note, the *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rates showed a relative decrease of more than 7 percent. Three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2021. 'Ohana QI met or exceeded the established targets for only one of these measure rates.

Table 3-58—'Ohana QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Cervical Cancer Screening				
Cervical Cancer Screening	47.20%	43.55%	-7.73%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	86.42%	79.58%	-7.91%	★★
Postpartum Care	72.83%	71.48%	-1.85%	★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
[1] MY 2021 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 3-59. Two rates in this domain reported a relative decrease of more than 10 percent (*Comprehensive Diabetes Care—Eye Exam [Retinal] Performed* and *Blood Pressure Control [<140/90 mm Hg]*). All three of the *Concurrent Use of Opioids and Benzodiazepines* measure rates demonstrated a relative decline of more than 5 percent. This indicates an increase in performance since a lower rate for this measure indicates better performance. With the exception of *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg),* all measure rates in this domain that could be compared to national benchmarks ranked at or above the 50th percentile, three of which ranked at or above the 75th percentile. 'Ohana QI met the HEDIS MY 2021 MQD Quality Strategy target for two measure rates within this domain: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *Concurrent Use of Opioids and Benzodiazepines—Total*.

Table 3-59—'Ohana QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Comprehensive Diabetes Care				
HbA1c Testing	82.73%	87.35%	5.58%	★★★★
*HbA1c Poor Control (>9.0%)**	39.17%	37.47%	-4.34%	★★★★
HbA1c Control (<8.0%)	53.28%	52.55%	-1.37%	★★★★
Eye Exam (Retinal) Performed	61.31%	54.01%	-11.91%	★★★
Blood Pressure Control (<140/90 mm Hg)	59.61%	53.28%	-10.62%	★★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	21.63%	19.90%	-8.00%	NC

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
65+ Years	17.62%	16.60%	-5.79%	NC
Total	20.76%	19.14%	-7.80%	NC
Controlling High Blood Pressure				
18-64 Years	—	57.20%	—	NC
65-85 Years	—	61.49%	—	NC
Total (18-85 Years)	—	58.88%	—	★★★

** A lower rate indicates better performance.*
Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-60. The *Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up—18–64 Years* measure rate demonstrated a relative increase of more than 7 percent, the *Screening for Depression and Follow-Up Plan—12–17 Years* measure rate showed a relative increase of more than 11 percent, and the *Use of Pharmacotherapy for Opioid Use Disorder—Total* and *Buprenorphine* measure rates showed a relative increase of more than 9 percent and 35 percent, respectively. Four measure rates that were compared to national benchmarks ranked at or above the 50th percentile, with two of these rates ranking above the 75th percentile and one rate ranking at or above the 90th percentile. 'Ohana QI met or exceeded the MQD's established Quality Strategy targets for HEDIS MY 2021 for six measure rates within this domain.

Table 3-60—'Ohana QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	51.27%	54.96%	7.20%	★★★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	50.81%	53.15%	4.61%	★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	73.42%	68.70%	-6.43%	★★★★

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	70.81%	67.13%	-5.20%	★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation—Total—13–17 Years	—	NA	—	NC
Initiation—Total—18+ Years	—	39.97%	—	★
Initiation—Total—Total	—	39.92%	—	★
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18+ Years	—	11.45%	—	★★
Engagement—Total—Total	—	11.42%	—	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	14.22%	15.87%	11.60%	NC
18–64 Years	8.20%	7.86%	-4.15%	NC
65 Years and Older	25.03%	23.27%	-7.03%	NC
18 Years and Older	12.08%	11.61%	-3.89%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	46.33%	50.70%	9.43%	NC
Buprenorphine	16.61%	22.54%	35.70%	NC
Oral Naltrexone	1.60%	0.35%	-78.13%	NC
Long-Acting, Injectable Naltrexone	0.00%	0.00%	—	NC
Methadone	30.35%	31.69%	4.42%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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 2021 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*

Long-Term Services and Supports Performance Measure Results

'Ohana QI's Long-Term Services and Supports performance measure results are shown in Table 3-61. MY 2021 represented the first year for reporting the measures in this domain; therefore, no prior years' rates are presented. In addition, the measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established. All measure rates in this domain were determined to be *Reportable.*

Table 3-61—'Ohana QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level
LTSS Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	—	12.50%	—	NC
Care plan with Supplemental Elements Documented	—	12.50%	—	NC
LTSS Minimizing Institutional Length of Stay				
Observed Discharge Rate	—	8.95%	—	NC
Expected Discharge Rate	—	29.01%	—	NC
Observed/Expected Ratio	—	0.31	—	NC
LTSS Shared Care Plan with Primary Care Practitioner				
Shared Care Plan with Primary Care Practitioner	—	3.13%	—	NC

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.

Conclusions and Recommendations

Based on HSAG's analyses of 'Ohana QI's 37 measure rates comparable to benchmarks, 11 measure rates (29.7 percent) ranked at or above the 50th percentile, with four measure rates (10.8 percent) ranking at or above the 75th percentile and two rates (4.9 percent) ranking at or above the 90th percentile, indicating positive performance in follow-up visits for members who were hospitalized due to mental illness and appropriate management of members with high blood pressure and members with diabetes. Additionally, 'Ohana QI met 10 of the MQD Quality Strategy targets for HEDIS MY 2021.

Conversely, 26 measure rates comparable to benchmarks (70.3 percent) ranked below the 50th percentile, with 17 measure rates (46.0 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
  - *Child and Adolescent Well-Care Visits—18–21 Years* and *Total*
  - *Childhood Immunization Status—Combination 3, Combination 7*, *DTaP*, *Hepatitis A, Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate, Rotavirus,* and *VZV*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- Women's Health

  - *Cervical Cancer Screening*
- Behavioral Health
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—18+ Years* and *Initiation—Total—Total*

Validation of Performance Improvement Projects

In CY 2022, the MQD selected two new PIPs—*Behavioral Health Coordination* and *Plan All-Cause Readmissions* for all the health plans to complete. For the CY 2022 submission, the health plans progressed to the Design and Implementation stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The health plan will be assessed for improvement in outcomes (Step 9) in the next validation cycle.

Table 3-62 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-62—CY 2022 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design and Implementation Stage (Steps 1 through 8)	07/01/2021 to 09/30/2021	Baseline
Plan All-Cause Readmissions	PIP Design and Implementation Stage (Steps 1 through 8)	CY 2021	Baseline

The focus of the nonclinical *Behavioral Health Coordination* (BH) PIP is to integrate care between the DOH Behavioral Health Services Administration divisions, CCS, and the QI Health Plans. This includes developing an infrastructure to streamline communication, information sharing, and continuity and coordination of care across agencies that provide services for a population with severe persistent mental illness, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by the MQD in consultation with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG.

The focus of the clinical *Plan All-Cause Readmissions* PIP is to decrease unplanned member readmission rates. The performance indicator for this PIP is based on the HEDIS *PCR* measure.

Findings

Table 3-63 illustrates the validation results for the two PIPs submitted by ‘Ohana QI for CY 2022 validation.

Table 3-63—CY 2022 PIP Validation Results for ‘Ohana QI

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	93%	100%	*Met*
Plan All-Cause Readmissions	93%	100%	*Met*

For both PIPs, ‘Ohana QI received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 93 percent for overall evaluation elements across all steps completed and validated.

Design (Steps 1-6)

Behavioral Health Coordination

‘Ohana QI met nine out of the 10 evaluation elements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD. The MQD held workgroup sessions with HSAG, health plans, and DOH Behavioral Health Services Administration divisions to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. ‘Ohana QI documented the PIP design accurately and as discussed during the workgroup meetings. ‘Ohana QI’s data collection process as documented appeared methodologically sound; however, the data collection process was not comprehensive at the time of the PIP submission. The health plan reported 21.23 percent administrative data completeness at the time the data were pulled. Additionally, ‘Ohana QI was yet to define its processes to capture the denominator data for all the trigger events identified in Indicator 1. The data sharing processes with the DOH Behavioral Health Service Administration divisions were also to be determined.

Plan All-Cause Readmissions

‘Ohana QI met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. ‘Ohana QI’s Aim statement set the focus of the PIP and the framework for data collection and analysis of results. ‘Ohana QI clearly defined the eligible population and the performance indicator, which aligned with the HEDIS specifications. ‘Ohana QI’s data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

'Ohana QI reported the baseline rates as available for the two performance indicators. 'Ohana QI documented its quality improvement efforts toward implementing the MQD-mandated interventions for this PIP. 'Ohana QI documented that it was participating in regular workgroup meetings with partnering agencies to discuss data sharing and identify the gaps in information needed by health plans and CCS.

Plan All-Cause Readmissions

'Ohana QI accurately reported the baseline numerator, denominator, and percentage rate for the performance indicator. 'Ohana QI conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes.

Analysis of Results

Table 3-64 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-64—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
3. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 18 D: 338	5.3%		
4. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 484 D: 2,016	24.0%		

N–Numerator D–Denominator

The baseline rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period was 5.3 percent. The health plan documented that the data collection process for a few of the trigger events (care transitions, a child who opts out of receiving health services, shared members who have recently turned 18 years of age, and shared members with challenging or breakthrough behavioral issues and substance use disorder) were yet to be determined at the time of PIP submission. Additionally, only formal reviews were included in the baseline data.

The baseline rate for the percentage of shared members whose data were actively shared with the partner agencies during the measurement period was 24.0 percent.

The mechanisms for sharing data with other DOH agencies were in the process of being researched and developed by the health plan.

Table 3-65 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-65—Performance Improvement Project Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. For members 18–64 years old, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	N: 133 D: 1,384	9.6%		

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one unplanned acute readmission for any diagnosis within 30 days of the Index Discharge Date was 9.6 percent. The health plan will be assessed for statistically significant improvement in the performance indicator rate in the next annual submission.

Barriers/Interventions

A health plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions documented by the health plans for appropriateness to the barriers identified and the timeliness of the implementation of the interventions.

Table 3-66 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-66—Interventions Implemented/Planned for 'Ohana QI PIPs

PIP Topic	Barriers	Interventions
Behavioral Health Coordination	1. Identifying data sharing and standardization of data. No data exchange agreement is in place currently. 2. Identifying gaps in data and workflow among health plans and CCS.	1. Drafting and executing MOUs with the partnering agencies regarding data sharing.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*

PIP Topic	Barriers	Interventions
Plan All-Cause Readmissions	1. High utilizers with readmissions within 30 days or difficult discharges with no viable discharge plan. 2. Members readmitting due to avoidable reasons; members lost to contact upon leaving hospital.	1. Multidisciplinary rounds within health plan to discuss high utilizers. 2. Contact with all members post-discharge via transition of care process.

* The documented interventions are required by the MQD.

Strengths

- For both PIPs, ‘Ohana QI received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 93 percent of overall evaluation elements across all steps completed and validated.
- For the *Behavioral Health Coordination* PIP, the health plan had initiated collaborative discussions with the partnering agencies for data sharing and combined reviews.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the reported baseline data were not comprehensive, as they did not include all the trigger events and data sharing information with all the partnering agencies. The health plan should work toward improving its data capturing and sharing capabilities with all the partnering agencies and in accordance with the PIP specifications.
- For the *Plan All-Cause Readmissions* PIP, the health plan should initiate interventions identified by the Readmissions Collaborative workgroup.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- The health plan should continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP:
  - The health plan should document its progress toward implementing the interventions and expanding the data sharing efforts with all the partnering agencies, including the DOH agencies.
  - The baseline data for the performance indicators should be updated as the health plan determines the information sharing and data collection processes for all the trigger events and with all the partnering agencies.
  - Even though the PIP measurement periods are based on the third quarter in a calendar year, the health plan should collect the performance indicators’ data on a quarterly basis and report quarterly data in Step 7 of the PIP Submission Form.

  - The health plan should capture any informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The health plan should update Step 3 and Step 5 of the PIP Submission Form with any changes made to the performance indicator specifications; for example, any changes to the combined review trigger events that were approved by the MQD should be updated in the next annual submission.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan should document the barriers, interventions, and quality improvement activities undertaken as part of the Readmissions Collaborative workgroup to improve the *PCR* rate.
  - The health plan should continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
  - The health plan should have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
  - The health plan must address the validation feedback associated with any *Met* score and *Partially Met* comments in the next annual submission.
  - The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
  - The health plan should seek technical assistance from HSAG and the MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-67 presents the 2022 percentage of top-box responses (i.e., top-box scores) for ‘Ohana QI compared to the 2021 NCQA adult Medicaid national averages and the corresponding 2020 scores.[3-16, 3-17] Additionally, the overall member experience ratings (i.e., star ratings) resulting from ‘Ohana QI’s top-

[3-16] The adult population was last surveyed in 2020; therefore, the 2022 adult CAHPS scores are compared to the corresponding 2020 scores.

[3-17] National Committee for Quality Assurance. *HEDIS® Measurement Year 2021*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2021.

box scores compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-18]

Table 3-67—Adult Medicaid CAHPS Results for 'Ohana QI

Measure	2020 Scores	2022 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	62.5%	60.2%	★★
Rating of All Health Care	55.3%	53.6%	★
Rating of Personal Doctor	68.7%	71.5%	★★★
Rating of Specialist Seen Most Often	68.9%	71.9%	★★★
Composite Measures			
Getting Needed Care	82.0%	80.4%	★
Getting Care Quickly	82.7%	77.5%	★
How Well Doctors Communicate	92.4%	91.7%	★★
Customer Service	87.0%	83.6%	★
Individual Item Measure			
Coordination of Care	87.4%	88.5%	★★★★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2021 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2021 NCQA adult Medicaid national averages.

▲ Indicates the 2022 score is statistically significantly higher than the 2020 score.

▼ Indicates the 2022 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

Strengths

For 'Ohana QI's adult Medicaid population, the following measure met or exceeded the 75th percentile:

- *Coordination of Care*

[3-18] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

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 3-68 provides a summary of the key drivers identified for 'Ohana QI.

Table 3-68—'Ohana QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Q4. Received care as soon as needed when care was needed right away		✓	
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	
Q20. Received appointment with a specialist as soon as needed	✓		**N/A**
Q24. Health plan's customer service gave 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 and timeliness for 'Ohana QI:

- Respondents reported not always receiving care as soon as they needed when care was needed right away.
- Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their plan.
- Respondents reported not always receiving an appointment with a specialist as soon as they needed.

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

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

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 five EQR activities. While ‘Ohana QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on certain compliance standards and outcome and process measures showed room for improvement.

‘Ohana QI’s performance during the 2022 compliance review was below average, meeting or exceeding the statewide compliance score for three of the eight standards. ‘Ohana QI achieved 100 percent compliance in three standards; however, the scores in the remaining five standards were all below the statewide averages for those standards. ‘Ohana QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor ‘Ohana QI’s CAP activities until the health plan is found to be in full compliance.

‘Ohana QI maintained robust systems for updating, verifying, storing, and sharing provider network data in accordance with State expectations. HSAG’s CY 2022 NAV findings suggest that ‘Ohana QI’s current provider network data systems and processes, as reported by the health plan in the PDSQ, are sufficient to support future NAV activities.

Overall, nearly two-thirds (70.3 percent) of ‘Ohana QI’s performance measures fell below the 50th percentile across all domains, with close to half (46.0 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS MY 2020, ‘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 Behavioral Health domains. Overall, 10 of the MQD Quality Strategy targets were met or exceeded in HEDIS MY 2021.

‘Ohana QI’s CAHPS results illustrate opportunities for improvement in members’ experience. While none of the measures scored statistically significantly lower in 2022 than in 2020 and none of the measures scored statistically significantly lower than the 2021 NCQA adult Medicaid national averages, the following six measures were below the 50th percentiles: *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. These results indicate the need for ‘Ohana QI to implement improvement strategies to ensure that members have high-quality care and timely access to care.

While none of the three measures the MQD selected for monitoring within its Quality Strategy met or exceeded the 75th percentiles, ‘Ohana QI should focus improvement efforts on the *Getting Needed Care* measure, which fell below the 25th percentile.

Finally, ‘Ohana QI progressed to the Design and Implementation stages of the two new PIP topics selected in CY 2022. The topics addressed CMS’ requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, ‘Ohana QI received an overall *Met* validation status. The reported baseline data were not comprehensive, as they did not include all the trigger events and data sharing information with all the partnering agencies.

For the *Plan All-Cause Readmissions* PIP, 'Ohana QI received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The health plan will be assessed for improvement in outcomes in the next validation cycle.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

Compliance Monitoring Review

The 2022 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-69 presents the standards and compliance scores for UHC CP QI.

Table 3-69—Standards and Compliance Scores—UHC CP QI

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Availability of Services	17	17	17	0	0	0	100%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	0	100%
III	Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV	Confidentiality	9	9	9	0	0	0	100%
V	Coverage and Authorization of Services	31	31	31	0	0	0	100%
VI	Enrollee Information	19	19	17	2	0	0	95%
VII	Enrollee Rights and Protections	8	8	7	1	0	0	94%
VIII	Grievance and Appeal System	31	31	30	1	0	0	98%
	Totals	**128**	**128**	**124**	**4**	**0**	**0**	**98%**

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

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

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

Strengths

UHC CP QI was found to be 100 percent compliant with the Availability of Services and Assurances of Adequate Capacity of Services standards. UHC CP QI had policies and procedures in place to monitor its network and ensure that all covered services were available and accessible to its members in a timely manner and met the standards developed by the State for network adequacy. Services included in the contract were made available to members 24 hours a day, seven days a week, when medically necessary.

UHC CP QI had Network Access and Adequacy teams at both the national and local levels that performed ongoing monitoring activities to ensure network adequacy. UnitedHealthcare used a Red, Yellow, Green Report that identified provider gaps and notified UHC CP QI to take action to resolve the gaps. Additionally, UHC CP QI used various GeoAccess and Quest Analytics tools and reports to monitor its network. To address provider gaps in the network, UHC CP QI used data to validate that a gap existed, notified the appropriate departments, identified potential nonparticipating providers, and initiated contracting outreach.

The health plan was also found to be fully compliant with the Coordination and Continuity of Care standard. UHC CP QI had comprehensive policies, procedures, processes, and staff in place to deliver and coordinate the care of its members. UHC CP QI demonstrated the implementation of its policies and procedures, and ability to coordinate the care of its members through a review of care coordination files. The files were well organized and provided evidence that HFAs and HAPs were completed in a timely manner, members were involved in the development of the HAP, health coordinators ensured member privacy was protected during care coordination activities, and the HAP and any other relevant information was shared with the member's PCP and other involved providers. Members were provided the contact information of their assigned health coordinator and were also able to send messages directly to the health coordinator through UHC CP QI's member portal. UHC CP QI used various reports and tracking mechanisms for ongoing monitoring and oversight of its health coordinators to ensure all health plan, State, and federal requirements and timelines were being met.

UHC CP QI was also 100 percent compliant with the Confidentiality standard. UHC CP QI had policies and procedures that addressed all aspects related to the use and disclosure of PHI and PII. All newly hired staff members are required to receive privacy and security training at the time of hire and on an annual basis. UHC CP QI had monitoring mechanisms that ensured that PHI and PII were safeguarded and released only with a member's authorization and in alignment with applicable federal regulations.

The health plan was also fully compliant the Coverage and Authorization of Services standard. Through documented policies and procedures, UHC CP QI provided evidence that it had the appropriate mechanisms in place for receiving, reviewing, processing, and monitoring service authorization decisions for members and providers. UHC CP QI's policies and procedures met the requirements for providing and paying for emergency, urgent, and poststabilization services; for ensuring consistent application of UM criteria (by conducting interrater reliability reviews); and for providing the required covered array of Medicaid services. UHC CP QI demonstrated the implementation of its authorization policies and procedures through a review of service authorization denial files. The files were well organized and provided evidence that UHC CP QI monitored its internal utilization management processes to ensure timeliness and consistency of authorization decisions. All decisions were made within the required time frames and by providers with the appropriate clinical expertise. The NABDs were written in a manner that was easily understood, at or below a sixth-grade reading level, and sent to the member and requesting provider.

UHC CP QI also scored high in the Grievance and Appeal System standard with 98 percent compliance, and with only one of the 31 elements scoring *Partially Met.* UHC CP QI had well-defined policies, procedures, and systems for logging, tracking, and reporting member grievances and appeals. The health

plan maintained several coordinators dedicated to the processing of grievances and appeals. A review of grievance and appeal files found that all cases were acknowledged and resolved within the required time frames, and notifications to members were written in a manner and format that was easily understandable.

Areas for Improvement

The greatest room for improvement for UHC CP QI was within the Enrollee Information and Enrollee Rights and Protections standards, with three elements found to be *Partially Met* among the two standards. In general, UHC CP QI had member information, customer service staff members, and service coordinators available to help members understand the requirements and benefits of the plan. Additionally, UHC CP QI maintained policies, procedures, and written member and provider information regarding member rights. The health plan ensured protection of member rights through the provision of education and training of staff members and providers, as well as monitoring of grievances and appeals, member and provider survey results, and the dissemination of member rights information in the provider manual and provider newsletters. The corrective actions required by UHC CP QI were related to updates to policy in the event of a provider termination, updates to the member handbook to ensure it included information about the specific locations for emergency settings, and updates to the advanced directives policy.

Validation of Network Adequacy

Findings

Provider data structure: UHC CP QI reported that its demographic and contractual data were stored within the UnitedHealthcare source system Network Database (NDB). Data were subsequently fed on a nightly basis to CSP Facets, which was the claims platform used for processing network provider claims.

Delegated services: UHC CP QI reported delegating some services (i.e., contracting all or part of the provision of selected services, such as BH services) to another entity. Table 3-70 summarizes UHC CP QI's delegated provider type/services, delegated entity names, and the frequency with which the health plan received provider data from the delegated entity at the time of the questionnaire response.

Table 3-70—UHC CP QI Delegated Services

Provider Type/Service	Delegated Entity Name	Provider Data Frequency
Behavioral Heath	Optum BH	Daily updates via NDB proprietary interchange
Pharmacy	Optum Rx	Daily via Optum Rx National Council for Prescription Drug Programs (NCPDP) Network file
Transportation	ModivCare	Daily via ModivCare

Delegated provider networks for UHC CP QI were covered in the Health Plan's oversight and monitoring of delegated services policies and procedures.

UHC CP QI conducted a weekly meeting and quarterly joint operating committee (JOC) with ModivCare to discuss network concerns and updates. Optum Behavioral Health and Optum Rx both conducted a quarterly JOC with UHC CP QI where generated reports and other contracted services were reviewed, and any concerns/issues could be discussed. Provider network reporting information was submitted quarterly to the MQD.

Provider classification data collection and maintenance: UHC CP QI reported collecting and maintaining data regarding provider classification in accordance with the current PNA methodology established by the MQD.

Provider indicators: HSAG asked each health plan to specify whether its provider data system included fields for the following provider indicators: PCP, Prenatal Care Providers, BH Providers, HCBS Providers, Active/Inactive Providers, Telehealth Providers, and SUD Providers, including those offering MAT. Table 3-71 details UHC CP QI's reported responses and additional information regarding provider indicators.

Table 3-71—UHC CP QI Provider Indicators

Provider Indicators	In Data System?	If Yes, Methods for Classifying Providers
PCPs	Yes	NDB; Provider Recommendation Engine (PRE) system assignments and maintenance
Prenatal Care Providers	Yes	NDB
Behavioral Health Providers	Yes	Optum BH network classifications
SUD Treatment Providers, including providers offering MAT	Yes	NDB
HCBS Providers	Yes	NDB
Active/Inactive Providers	Yes	NDB
Telehealth Providers	Yes	NDB

Providers accepting new patients: UHC CP QI confirmed that its provider data system included fields to identify providers accepting new patients for all participating provider types.

Panel capacity: UHC CP QI reported that the NDB and CSP Facets claim systems did contain a field for maintaining panel capacity information, which was available through reporting. UHC CP QI used predetermined plan enrollment rules and loading limits to assess the maximum capacity for each provider. UHC CP QI could also establish practitioner panel size based on contract discussions/negotiations. In some cases, providers could also contact their network representative

(network management contractor, physician advocate, and/or an assigned roster manager for applicable delegated groups) and request that their panel size be changed.

Use of single case agreements: UHC CP QI reported that SCAs or LOAs were identified and tracked using an internal SharePoint site, Single Case Agreement Navigation System (SCAN). This is a single repository for all SCAs, allowing for visibility in all steps of the SCA process, including a historical repository of all executed agreements. SCAs are defined as a contract between UHC CP QI and nonparticipating providers to pay for services rendered for a specific patient and episode. SCAs cover individual Medicaid members for typically a period of one year, as has been authorized and approved internally for medically necessary services that are not available through an in network contracted provider on the member's home island, on another island, or out of state.

Provider network monitoring: UHC CP QI monitored the adequacy of its provider network and members' ability to access necessary services in multiple ways. UHC CP QI used the PNA report, which was submitted to the MQD on a quarterly basis to ensure an adequate network of providers within adequate time and distance standards. UHC CP QI also used the Timely Access Report (TAR), which was submitted to MQD quarterly to ensure that its network of providers meets the timely access standards set by the State. Additionally, UHC CP QI gathered information on the adequacy of its provider network through internal departments, such as issues brought to Appeals and Grievances, Enrollee and Provider Services, Provider Relations Advocacy, and externally from providers and members.

Health plans' provider data verification and cleaning: UHC CP QI employed proactive outreach campaigns that used multiple channels in order to routinely review and update directories, including email, phone calls, faxes, in-person meetings, obtaining data from vendors and other sources, the use of cloud-based technology, and the use of claims data. UHC CP QI requested that providers attest to the accuracy of their data every quarter. UHC CP QI required all licensed healthcare professionals to complete credentialing to participate in the UHC CP QI network and prior to seeing UHC CP QI members. UHC CP QI followed the most current NCQA credentialing and recredentialing standards, including delegation and provider monitoring/oversight.

Specifically for provider directories, UHC CP QI conducted ongoing quality reviews through provider data attestations, phone call campaigns to providers, and other methods. An attestation is a confirmation from a provider as to the accuracy of the provider's data that will be displayed in UHC CP QI's directories. On a monthly basis, UHC CP QI pulled records from its provider databases for a statistically valid sample size of providers. The sample was selected across all physician types and lines of business based on overall population. UHC CP QI then used the information collected through the phone calls, attestations, or other methods to compare records to its provider data to confirm accuracy, ensure completeness, and identify errors. UHC CP QI then updated the directory as needed. The directory was updated within 30 days of receipt of a confirmed update from the provider.

Communicating provider network information to members: Provider information for UHC CP QI was shared with Medicaid members online. All providers who were participating with UHC CP QI were displayed in the directory, and there were no services excluded. UHC CP QI also allowed members the

opportunity to request a paper copy of available providers/facilities via mail. This option included those members in rural areas in which the provider/facility was not within the 100-mile radius search that is available online. Members could also request a paper copy by calling Customer Service at the phone number listed on the back of their member ID card.

Strengths

UHC CP QI maintained detailed data regarding provider classifications (e.g., provider type, specialty, network participation, etc.) and provider indicators (e.g., PCP, SUD treatment providers, prenatal care providers) and reported multiple methods for updating, verifying, and cleaning provider data. UHC CP QI also used multiple methods for monitoring its provider network and communicating provider network information to members and maintained data regarding new patient acceptance and panel capacity for all provider types and specialties.

Areas for Improvement

HSAG did not identify areas for improvement for UHC CP QI regarding provider data maintenance and storage.

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 six standard and nine nonstandard supplemental data sources for MY 2021 performance measure reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2021 performance measure reporting.

UHC CP QI was required to undergo convenience sample validation for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Cervical Cancer Screening* measures. All cases successfully passed the validation process. The final MRRV was conducted for the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *HbA1c Poor Control (>9.0%), Cervical Cancer Screening, Childhood Immunization Status—Combination 7,* and *Controlling High Blood Pressure* measures, as well as all medical record exclusions. All records passed the validation without any critical issues.

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 denominators were 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 3-72. The one rate in this domain that could be compared to national benchmarks ranked below the 25th percentile. One rate for the non-HEDIS *Heart Failure Admission Rate* measure demonstrated a relative decline of more than 15 percent. This represents an improvement in performance since lower rates for this measure indicate better performance. One measure in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total*), and UHC CP QI met or exceeded the established target for HEDIS MY 2021.

Table 3-72—UHC CP QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Heart Failure Admission Rate*				
18-64 Years	55.08	46.28	-15.98%	NC
65+ Years	105.91	121.71	14.92%	NC
Total	69.42	66.62	-4.03%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	10.20%	11.73%	15.00%	★
Expected Readmissions—Total	11.07%	11.06%	-0.09%	NC
*Index Total Stays—O/E Ratio—Total**	0.92	1.06	15.26%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-73. All measure rates in this domain that could be compared to national benchmarks fell below the 50th percentile, 16 of which fell below the 25th percentile. The majority of measure rates in this domain demonstrated a relative decrease in performance. Additionally, only one rate in this domain (*Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*) reached the MQD Quality Strategy target for HEDIS MY 2021.

Table 3-73—UHC CP QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Child and Adolescent Well-Care Visits				
3–11 Years	40.93%	41.74%	1.98%	★
12–17 Years	35.86%	36.51%	1.81%	★
18–21 Years	14.77%	14.08%	-4.67%	★
Total	34.97%	35.16%	0.54%	★
Childhood Immunization Status				
Combination 2	64.72%	53.04%	-18.05%	NC
Combination 3	62.53%	51.58%	-17.51%	★
Combination 4	62.04%	51.34%	-17.25%	NC
Combination 5	51.34%	44.53%	-13.26%	NC
Combination 6	49.39%	40.15%	-18.71%	NC
Combination 7	51.09%	44.53%	-12.84%	★
Combination 8	49.15%	40.15%	-18.31%	NC
Combination 9	41.12%	35.28%	-14.20%	NC
Combination 10	41.12%	35.28%	-14.20%	★★
DTaP	67.40%	54.74%	-18.78%	★
Hepatitis A	77.62%	67.88%	-12.55%	★
Hepatitis B	82.24%	75.18%	-8.58%	★
HiB	80.78%	71.53%	-11.45%	★
Influenza	56.69%	50.36%	-11.17%	★★
IPV	81.75%	72.75%	-11.01%	★
MMR	80.54%	69.59%	-13.60%	★
Pneumococcal Conjugate	66.18%	55.47%	-16.18%	★
Rotavirus	61.31%	59.61%	-2.77%	★
VZV	78.35%	68.86%	-12.11%	★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	48.50%	49.58%	2.23%	★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	67.14%	52.88%	-21.24%	★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-74. Both *Prenatal and Postpartum Care* measure rates demonstrated a relative decline in performance of more than 5 percent. Conversely, the *Postpartum Care* measure rate met or exceeded the HEDIS MY 2021 50th percentile. Two of the three measure rates in this domain (*Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*) fell below the 25th percentile. UHC CP QI only met the established HEDIS MY 2021 MQD Quality Strategy target for one measure in this domain: : *Prenatal and Postpartum Care—Postpartum Care*.

Table 3-74—UHC CP QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Cervical Cancer Screening				
Cervical Cancer Screening	49.64%	50.85%	2.44%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	88.32%	78.35%	-11.29%	★
Postpartum Care	82.24%	78.10%	-5.03%	★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
[1] MY 2021 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 3-75. All six measure rates that could be compared to national benchmarks met or exceeded the 75th percentile, four of which met or exceeded the 90th percentile. The non-HEDIS measure *Concurrent Use of Opioids and Benzodiazepines* measure rates demonstrated a relative decrease in performance. This represents an increase in performance since lower rates indicate better performance for this measure. UHC CP QI met the HEDIS MY 2021 established MQD Quality Strategy target for five measure rates within this domain.

Table 3-75—UHC CP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Comprehensive Diabetes Care				
HbA1c Testing	87.10%	92.46%	6.15%	★★★★★
*HbA1c Poor Control (>9.0%)**	31.63%	29.20%	-7.68%	★★★★★
HbA1c Control (<8.0%)	57.91%	57.42%	-0.85%	★★★★★

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Eye Exam (Retinal) Performed	63.02%	63.26%	0.38%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	64.23%	69.59%	8.35%	★★★★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	17.04%	14.20%	-16.67%	NC
65+ Years	14.88%	14.52%	-2.42%	NC
Total	16.14%	14.33%	-11.21%	NC
Controlling High Blood Pressure				
18-64 Years	—	53.33%	—	NC
65-85 Years	—	73.15%	—	NC
Total (18-85 Years)	—	63.75%	—	★★★★

** A lower rate indicates better performance.*
Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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 3-76. The *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years* and *Total* indicators demonstrated a relative increase of more than 9 percent. Four measure rates that could be compared to national benchmarks ranked at or above the 50th percentile, with one of these rates ranking at or above the 75th percentile. Conversely, four measure rates fell below the 25th percentile. Of note, the *Screening for Depression and Follow-Up Plan—65 Years and Older* rate showed a relative increase of more than 5 percent, and the *Use of Pharmacotherapy for Opioid Use Disorder—Total, Oral Naltrexone,* and *Methadone* measure rates demonstrated a relative increase of more than 5 percent. UHC CP QI met or exceeded the established MQD Quality Strategy target for six measure rates for HEDIS MY 2021.

Table 3-76—UHC CP QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	46.06%	47.67%	3.50%	★★★★

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	45.43%	47.37%	4.27%	★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	57.88%	63.21%	9.21%	★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	57.34%	62.72%	9.38%	★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation—Total—13–17 Years	—	NA	—	NC
Initiation—Total—18+ Years	—	34.70%	—	★
Initiation—Total—Total	—	34.73%	—	★
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18+ Years	—	8.84%	—	★
Engagement—Total—Total	—	8.88%	—	★
Screening for Depression and Follow-Up Plan				
12–17 Years	16.06%	16.43%	2.30%	NC
18–64 Years	7.61%	7.65%	0.53%	NC
65 Years and Older	26.18%	27.74%	5.96%	NC
18 Years and Older	14.11%	14.81%	4.96%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total	42.08%	45.78%	8.79%	NC
Buprenorphine	23.90%	23.43%	-1.97%	NC
Oral Naltrexone	0.78%	0.82%	5.13%	NC
Long-Acting, Injectable Naltrexone	0.00%	0.27%	—	NC
Methadone	19.48%	23.71%	21.71%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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*

Long-Term Services and Supports Performance Measure Results

UHC CP QI's Long-Term Services and Supports performance measure results are shown in Table 3-77. MY 2021 represented the first year for reporting the measures in this domain; therefore, no prior years' rates are presented. In addition, the measures in this domain did not have applicable benchmarks;

therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established. All measure rates in this domain were determined to be *Reportable.*

Table 3-77—UHC CP QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level
LTSS Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	—	6.25%	—	NC
Care plan with Supplemental Elements Documented	—	6.25%	—	NC
LTSS Minimizing Institutional Length of Stay				
Observed Discharge Rate	—	19.88%	—	NC
Expected Discharge Rate	—	33.16%	—	NC
Observed/Expected Ratio	—	0.60	—	NC
LTSS Shared Care Plan with Primary Care Practitioner				
Shared Care Plan with Primary Care Practitioner	—	1.04%	—	NC

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.

Conclusions and Recommendations

Based on HSAG's analyses of UHC CP QI's 37 measure rates comparable to benchmarks, 11 measure rates (29.7 percent) ranked at or above the 50th percentile, with three of these rates (8.1 percent) ranking at or above the 75th percentile and three rates (8.1 percent) ranking at or above the 90th percentile, indicating positive performance in several areas, including follow-up visits for members hospitalized for mental illness, care for members with diabetes and high blood pressure, and postpartum care visits. Additionally, UHC CP QI met 14 of the MQD Quality Strategy targets for HEDIS MY 2021.

Conversely, 26 of UHC CP QI's 37 measure rates comparable to benchmarks (70.3 percent) fell below the 50th percentile, with 23 of these rates (62.2 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
  - *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*
- Children's Preventive Health
  - *Child and Adolescent Well-Care Visits—3–11 Years, 12–17 Years, 18–21 Years,* and *Total*

  - *Childhood Immunization Status—Combination 3, Combination 7, DTaP, Hepatitis A, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, Rotavirus,* and *VZV*
  - *Well-Child Visits in the First 30 Months of Life—Age 15 Months to 30 Months—Two or More Well-Child Visits*
- Women's Health
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Validation of Performance Improvement Projects

In CY 2022, the MQD selected two new PIPs—*Behavioral Health Coordination* and *Plan All-Cause Readmissions* for all the health plans to complete. For the CY 2022 submission, the health plans progressed to the Design and Implementation stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The health plan will be assessed for improvement in outcomes (Step 9) in the next validation cycle.

Table 3-78 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-78—CY 2022 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design and Implementation Stage (Steps 1 through 8)	07/01/2021 to 09/30/2021	Baseline
Plan All-Cause Readmissions	PIP Design and Implementation Stage (Steps 1 through 8)	CY 2021	Baseline

The focus of the nonclinical *Behavioral Health Coordination* (BH) PIP is to integrate care between the DOH Behavioral Health Services Administration divisions, CCS, and the QI Health Plans. This includes developing an infrastructure to streamline communication, information sharing, and continuity and coordination of care across agencies that provide services for a population with severe persistent mental illness, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by the MQD in consultation with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG.

The focus of the clinical *Plan All-Cause Readmissions* PIP is to decrease unplanned member readmission rates. The performance indicator for this PIP is based on the HEDIS *PCR* measure.

Findings

Table 3-79 illustrates the validation results for the two PIPs submitted by UHC CP QI for CY 2022 validation.

Table 3-79—CY 2022 PIP Validation Results for UHC CP QI

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	100%	100%	*Met*
Plan All-Cause Readmissions	100%	100%	*Met*

For both PIPs, UHC CP QI received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 100 percent for overall evaluation elements across all steps completed and validated.

Design (Steps 1-6)

Behavioral Health Coordination

UHC CP QI met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD. The MQD held workgroup meetings with health plans, DOH Behavioral Health Services Administration divisions, and HSAG to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. UHC CP QI documented the PIP design accurately and as discussed during the workgroup meetings. UHC CP QI's data collection process as documented appeared methodologically sound; however, the data collection process was not comprehensive at the time of the PIP submission. UHC CP QI was in the process of defining its processes to capture the denominator data for all the trigger events identified in Indicator 1. Additionally, the data sharing processes and combined review processes with the DOH divisions were to be determined.

Plan All-Cause Readmissions

UHC CP QI met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. UHC CP QI's Aim statement set the focus of the PIP and the framework for data collection and analysis of results. UHC CP QI clearly defined the eligible population and the performance indicator, which aligned with the HEDIS specifications. UHC CP QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

UHC CP QI reported the baseline rates as available for the two performance indicators. UHC CP QI documented its quality improvement efforts toward implementing the MQD-mandated interventions for this PIP. UHC CP QI assessed its internal existing care coordination processes with partnering agencies and identified the need to develop standardized processes for identifying and tracking shared CCS and DOH members who experience the different triggering events and whose data are actively being shared with partnering entities. UHC CP QI indicated that workflows for ongoing communication, tracking informal combined reviews, and information sharing with the partnering agencies were yet to be determined at the time of the PIP submission.

Plan All-Cause Readmissions

UHC CP QI accurately reported the baseline numerator, denominator, and percentage rate for the performance indicator. UHC CP QI conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes.

Analysis of Results

Table 3-80 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-80—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 21 D: 102	20.6%		
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 849 D: 223	32.2%		

N–Numerator D–Denominator

The baseline rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 20.6 percent. The health plan documented that Indicator 1 data only included shared members who were hospitalized and received an interdisciplinary team (IDT) meeting between UHC CP QI and ‘Ohana CCS. Also, the numerator did not account for informal reviews. The baseline data may be updated by the health plan in

the next annual submission once the processes for capturing data for all the remaining trigger events and combined reviews are determined.

The baseline rate for the percentage of shared members whose data were actively shared with the partner agencies during the measurement period was 4.0 percent. UHC CP QI documented that at the time of the PIP submission, it did not have a process to track shared members who receive services with the DOH entities. The reported numerator data captured data sharing with ‘Ohana CCS only.

Table 3-81 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-81—Performance Improvement Project Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. For members 18–64 years old, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	N: 133 D: 1,134	11.7%		

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one unplanned acute readmission for any diagnosis within 30 days of the Index Discharge Date was 11.7 percent. The health plan will be assessed for statistically significant improvement in the performance indicator rate in the next annual submission.

Barriers/Interventions

A health plan’s success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions documented by the health plans for appropriateness to the barriers identified and the timeliness of the implementation of the interventions.

Table 3-82 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-82—Interventions Implemented/Planned for UHC CP QI PIPs

PIP Topic	Barriers	Interventions
Behavioral Health Coordination	1. Uncertainty regarding current data exchange processes; unclear internal and external workflows across entities.	1. Assess current data exchange and workflow processes between the different partnering agencies.

PIP Topic	Barriers	Interventions
	2. Lack of systematic data exchange and outcome reporting across entities; lack of automated internal processes for reporting and data exchange; many reporting practices are currently manual. 3. Inconsistent and unclear data reporting requirements. 4. Lack of consistent definition of triggering events and collaborative processes in response to these events; inconsistent responses to triggering events across partnering agencies. 5. Unclear processes on reporting and data exchange; lack of processes for data sharing for some triggering events and partnering agencies. 6. Uncertain points of contact with partnering agencies and within health plan to streamline communication. 7. Inconsistent collaboration with DOH entities; limited systems view of coordination of services between MCO and partnering agencies. 8. Unclear expectations and responsibilities across partnering agencies. 9. Lack of resources and unknown funding needed for system integration and data sharing.	2. Explore system capabilities for reporting outcomes. 3. Identify data fields/format/mechanisms/ reports for data sharing. 4. Explore current interface with partnering agencies for the triggering events. 5. Draft standard operating procedures (SOPs) on workflow processes for data sharing and execute upon agreement with partnering agencies. 6. Develop a workflow for ongoing communication between health plan and partnering agencies.* 7. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 8. Drafting and executing MOUs with the partnering agencies regarding data sharing.* 9. Explore funding needs for system integration and data sharing.
Plan All-Cause Readmissions	1. Lack of member understanding of the importance of following up after discharge. 2. Difficult/unable to reach member due to inaccurate/lack of contact information (address, phone number, etc.). 3. Member not adhering to discharge instructions or medication plan. 4. Member not established with their assigned PCP.	1. Expand member engagement to include family and/or other natural supports to promote the importance of follow-up care. 2. Develop process to obtain information from the member before discharge and collaborate with the PCP or other provider(s) to obtain information after discharge. 3. Member outreach program to include culturally appropriate education or materials to reiterate discharge instructions and medication plan with the member, family, or other natural supports.

PIP Topic	Barriers	Interventions
	5. Social determinants of health challenges (transportation, housing, etc.). 6. Lack of resources or inadequate or limited (untimely) access to services/support post-discharge. 7. Members with an underlying, untreated BH condition. 8. Untimely notification of discharges/discharge summary to the PCP and health plan (from the hospital). 9. Limited/inadequate resources to conduct follow-up (e.g., staffing shortages). 10. Lack of clarity in processes and workflows across entities (health plans, hospitals, PCPs).	4. Align PCP assignment with attribution (i.e., who the member is seeing) and collaborate with PCP to schedule an initial visit for non-established patients. 5. Assess and screen for social determinants of health needs to ensure adequate placement, services and supports, and care coordination post-discharge. 6. Early identification of services and supports needed and develop contingency plans. 7. Create a process with specific parameters for when to assess or screen for underlying, untreated BH conditions and coordinate with DOH agencies on providing services and supports for the member. 8. Provider education for hospitals on timely notification of discharges. 9. Collaborate with providers (e.g., accountable care organizations) to conduct follow-up after discharge, such as appointment reminders and scheduling. 10. Collaborative workgroup with hospitals and health plans to align activities and processes across entities.

* The documented interventions are required by the MQD.

Strengths

- For both PIPs, UHC CP QI received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- For the *Behavioral Health Coordination* PIP, the health plan had initiated collaborative discussions with the partnering agencies for data sharing and combined reviews.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the reported data for the two performance indicators were incomplete. The workflows for ongoing communication, tracking informal combined reviews, and information sharing with the partnering agencies were yet to be determined at the time of the PIP submission.

- For the *Plan All-Cause Readmissions* PIP, the health plan should initiate interventions identified by the Readmissions Collaborative workgroup.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- The health plan should continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP:
  - The health plan should document its progress toward implementing the interventions and expanding the data sharing efforts with all the partnering agencies.
  - The baseline data for the performance indicators should be updated as the health plan determines the information sharing and data collection processes for all the trigger events and with all the partnering agencies.
  - Even though the PIP measurement periods are based on the third quarter in a calendar year, the health plan should collect the performance indicators' data on a quarterly basis and report quarterly data in Step 7 of the PIP Submission Form.
  - The health plan should capture any informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The health plan should update Step 3 and Step 5 of the PIP Submission Form with any changes made to the performance indicator specifications; for example, any changes to the combined review trigger events that were approved by the MQD should be updated in the next annual submission.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan should document the barriers, interventions, and quality improvement activities undertaken as part of the Readmissions Collaborative workgroup to improve the *PCR* rate.
- The health plan should continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- The health plan should have a process in place for evaluating each PIP intervention and its impact on the performance indicator. The health plan's interventions should be adapted or revised as needed.
- The health plan must address the validation feedback associated with any *Met* score in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and the MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-83 presents the 2022 percentage of top-box responses (i.e., top-box scores) for UHC CP QI compared to the 2021 NCQA adult Medicaid national averages and the corresponding 2020 scores.[3-19, 3-20] Additionally, the overall member experience ratings (i.e., star ratings) resulting from UHC CP QI's top-box scores compared to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-21]

Table 3-83—Adult Medicaid CAHPS Results for UHC CP QI

Measure	2020 Scores	2022 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	66.1%	68.1%	★★★★
Rating of All Health Care	57.3%	68.1% ▲	★★★★★
Rating of Personal Doctor	71.3%	63.0%	★
Rating of Specialist Seen Most Often	69.2%	70.0%+	★★★
Composite Measures			
Getting Needed Care	79.6%	77.8%+	★
Getting Care Quickly	77.8%	74.5%+	★
How Well Doctors Communicate	94.5%	88.1% ▼	★
Customer Service	88.8%	83.6%+	★
Individual Item Measure			
Coordination of Care	89.3%	81.2%+	★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2021 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2021 NCQA adult Medicaid national averages.

▲ Indicates the 2022 score is statistically significantly higher than the 2020 score.

▼ Indicates the 2022 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

[3-19] The adult population was last surveyed in 2020; therefore, the 2022 adult CAHPS scores are compared to the corresponding 2020 scores.

[3-20] National Committee for Quality Assurance. *HEDIS® Measurement Year 2021, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2021.

[3-21] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021.* Washington, DC: NCQA, September 2021.

Strengths

For UHC CP QI's adult Medicaid population, the following measure scored statistically significantly higher than the 2021 NCQA adult Medicaid national average:

- *Rating of All Health Care*

In addition, the following measure scored statistically significantly higher in 2022 than in 2020:

- *Rating of All Health Care*

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

- *Rating of All Health Care*

Of the three MQD member satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*—UHC CP QI's member satisfaction rating 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*. UHC CP QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-84 provides a summary of the key drivers identified for UHC CP QI.

Table 3-84—UHC CP QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Q9. Ease of getting the care, tests, or treatment needed		✓	
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	✓	✓	
Q24. Health plan's customer service gave the information or help 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 and timeliness for UHC CP QI:

- Respondents reported that it was not always easy to get the care, tests, or treatment they thought they needed through their plan.

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

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

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 five EQR activities. While the compliance monitoring review and network adequacy activities revealed that UHC CP QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on outcome and process measures showed room for improvement.

UHC CP QI showed that it has 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. UHC CP QI's performance during the 2022 compliance review was above average, meeting or exceeding the statewide compliance score for seven of the eight standards. UHC CP QI achieved 100 percent compliance in five standards and scored below the statewide average in only one standard. UHC CP QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor UHC CP QI's CAP activities until the health plan is found to be in full compliance.

UHC CP QI maintained robust systems for updating, verifying, storing, and sharing provider network data in accordance with State expectations. HSAG's CY 2022 NAV findings suggest that United's current provider network data systems and processes, as reported by the health plan in the PDSQ, are sufficient to support future NAV activities.

While UHC CP QI performed well on the Care for Chronic Conditions performance measures, nearly two-thirds (70.3 percent) of UHC CP QI's measure rates fell below the 50th percentile, with more than half (62.2 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS MY 2020, UHC CP QI's performance demonstrated the need to improve process and outcome measures across most domains. In particular, UHC CP QI should address performance in the Children's Preventive Health, Women's Health, and Access and Risk-Adjusted Utilization domains. Overall, 14 of the MQD Quality Strategy targets were met in HEDIS MY 2021.

UHC CP QI's CAHPS results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower than the 2021 NCQA adult Medicaid national averages, the following six measures were below the 50th percentiles: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. Additionally, one measure scored statistically significantly lower in 2022 than in 2020: *How Well Doctors Communicate*. These results indicate the need for UHC CP QI to implement improvement strategies to ensure that members have high-quality care and timely access to care.

While one of the three measures the MQD selected for monitoring within its Quality Strategy met or exceeded the 75th percentiles, UHC CP QI should focus improvement efforts on the *Getting Needed Care* and *How Well Doctors Communicate* measures, which fell below the 25th percentile.

Finally, UHC CP QI progressed to the Design and Implementation stages of the two new PIP topics selected in CY 2022. The topics addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, UHC CP QI received an overall *Met* validation status. The reported baseline data were not comprehensive, as they did not include all the trigger events and data sharing information with all the partnering agencies.

For the *Plan All-Cause Readmissions* PIP, UHC CP QI received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The health plan will be assessed for improvement in outcomes in the next validation cycle.

'Ohana Community Care Services ('Ohana CCS) Results

Compliance Monitoring Review

The 2022 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-85 presents the standards and compliance scores for 'Ohana CCS.

Table 3-85—Standards and Compliance Scores—'Ohana CCS

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Availability of Services	14	14	13	1	0	0	96%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	0	100%
III	Coordination and Continuity of Care	9	9	9	0	0	0	100%
IV	Confidentiality	9	9	9	0	0	0	100%
V	Coverage and Authorization of Services	30	30	26	4	0	0	93%
VI	Enrollee Information	18	18	14	3	1	0	86%
VII	Enrollee Rights and Protections	7	7	6	1	0	0	93%
VIII	Grievance and Appeal System	31	31	31	0	0	0	100%
	Totals	**121**	**121**	**111**	**9**	**1**	**0**	**95%**

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

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

Strengths

'Ohana CCS was found to be 100 percent compliant with the Grievance and Appeal System standard. 'Ohana CCS had comprehensive policies, procedures, and systems for logging, tracking, and reporting member grievances and appeals, and the health plan maintained several staff members responsible for the processing of grievances and appeals. A review of grievance and appeal files found that all cases were acknowledged and resolved within the required time frames and notifications to members were written in a manner and format that was easily understandable.

The health plan was also found to be fully compliant with the Coordination and Continuity of Care standard. CCS had comprehensive policies, procedures, processes, and staff in place to deliver and coordinate the care of its members. Built around the individual member, the purpose of the CCS program is to assess, plan, implement, coordinate, monitor, and evaluate the options and behavioral health services required to meet a member's healthcare needs using all available resources to promote quality outcomes. Through a review of behavioral health care coordination files, 'Ohana CCS demonstrated the implementation of its policies and procedures and ability to coordinate the care of its members. All Behavioral Health Assessments (BHAs) were completed within 21 days of member enrollment into CCS, and all Individualized Treatment Plans (ITPs) were completed within 14 days of completion of the BHA. Comprehensive progress and member outreach notes were kept, and ITPs were updated as required. The files provided evidence that members were involved in the development of the ITP, and behavioral health coordinators/case managers ensured that member privacy was protected during care coordination activities. Members were provided the contact information of their assigned case management agency and case manager.

'Ohana CCS also scored 100 percent compliance in the Confidentiality standard. 'Ohana CCS demonstrated that it had in place policies and procedures that address the use and disclosure of PHI and PII. All newly hired staff members are required to receive privacy and security training at the time of hire and on an annual basis. In an effort to ensure continued compliance with and adherence to 'Ohana CCS' privacy, security, and confidentiality policies, oversight of computer and electronic mail systems, monthly customer service call center staff audits, and other routine reporting and monitoring efforts were conducted.

'Ohana CCS showed high performance in the Availability of Services and Assurances of Adequate Capacity and Services standards, scoring 96 percent and 100 percent compliance, respectively. 'Ohana CCS had policies and procedures in place to monitor its network and ensure that all covered services were available and accessible to its members in a timely manner and met the standards developed by the State for network adequacy. Services included in the contract were made available to members 24 hours a day, seven days a week, when medically necessary. 'Ohana CCS conducted ongoing monitoring of its network, which included the review of various monitoring reports, including GeoAccess reports, for any significant provider changes or losses, evaluation of specialist ratios, and a review of any provider gaps.

Finally, 'Ohana CCS showed high compliance in the Enrollee Rights and Protections standard, with only one element scoring *Partially Met*. 'Ohana CCS maintained policies, procedures, and written member and provider information regarding member rights. 'Ohana CCS ensured protection of member rights through the provision of education and training of staff members and providers, and monitoring call center staff members to evaluate adherence to member rights policies. 'Ohana CCS also reviewed member grievances related to violations of rights, which provided a chance to identify opportunities for enhanced training of staff and/or providers on member rights.

Areas for Improvement

The Coverage and Authorization of Services standard was found to be an area for improvement, with four elements scoring *Partially Met*. While 'Ohana CCS had policies, procedures, and program

descriptions that provided evidence that it had mechanisms in place for receiving, reviewing, processing, and monitoring service authorization decisions for members and providers, incorrect and inconsistent information was found among the various documents. Additionally, processes for ensuring readability of member notification letters were implemented inconsistently among staff members, and service termination procedures were not compliant with federal regulations. 'Ohana CCS was required to complete corrective actions to address the deficiencies in this standard.

Finally, 'Ohana CCS was found to be 86 percent compliant with the Enrollee Information standard, with three elements scoring *Partially Met* and one element scoring *Not Met.* In general, 'Ohana CCS had member information, customer service staff members, and behavioral health coordinators available to help members understand the requirements and benefits of the plan. The corrective actions required by 'Ohana CCS were related to updates to policies and procedures in the event of a provider termination, updates to the member handbook to ensure that it included information about the specific locations for emergency settings, and updates to the provider directory to include specific details regarding providers' office accommodations for people with physical disabilities and ensure a machine-readable version was accessible on the health plan's website.

Validation of Network Adequacy

Findings

Provider data structure: 'Ohana CCS reported that its provider data structure included Salesforce, iCertis, iBPS PLFs, and Xcelys software. Provider information was entered into Salesforce, which housed the provider's demographics, documentation of health plan outreach to the provider, and documents needed for credentialing. iCertis was the health plan's contract management system through which 'Ohana CCS created, managed, and executed contracts. iBPS was 'Ohana CCS' provider data management system that took the information received from providers and transferred it into the core processing system, Xcelys. Information obtained from the providers was transcribed into the PLF in preparation for provider load submission into Xcelys. Xcelys was where provider data were loaded and claims were processed. The provider's information was loaded under a unique provider identification number tied to each individual or facility. Xcelys housed 'Ohana CCS' provider data, which were linked to claims processing and contract reimbursement.

Delegated services: 'Ohana CCS reported delegating some services (i.e., contracting all or part of the provision of selected services, such as BH services) to another entity. Table 3-86 summarizes 'Ohana CCS' delegated provider type/services, delegated entity names, and the frequency with which the health plan received provider data from the delegated entity at the time of the questionnaire response.

Table 3-86—'Ohana CCS Delegated Services

Provider Type/Service	Delegated Entity Name	Provider Data Frequency
Non-Emergent Transportation	IntelliRide	Quarterly
Pharmacy Benefit Management	CVS	Daily via claims received
Community Based Case Management	Aloha House Care Hawaii Community Empowerment Resources Helping Hands Hawaii Hope Inc Institute for Human Services (IHS) Kokua Kalihi Valley Comp Family Services Kalihi Palama Health Clinic Mental Health Kokua North Shore Mental Health Inc State of Hawaii Dept of Health Waianae Coast Community Mental Health – Hale Naau Pono	Annually, unless the agency has a finding with a corrective action plan, then it is much more frequently
Behavior Health Providers within Hawaii Pacific Health Provider Network	Hawaii Pacific Health	As HPH identified providers added to their network, its representative would send them to 'Ohana CCS' Provider Data Management Team and update spreadsheet

Provider classification data collection and maintenance: 'Ohana CCS submitted information on selected provider categorization fields and supplied a corresponding data dictionary, as requested. Table 3-87 details all provider classifications in use by 'Ohana CCS, as well as the mechanism for reporting and frequency of updating these classifications.

Table 3-87—'Ohana CCS Provider Classifications

Provider Classification	Reporting Mechanism	Update Frequency
Provider Type	Received from State	State sent monthly via FTP PRM file drop which is processed into 'Ohana CCS' system and updated into the PMR back-end database.
Provider Specialty	Provider self-reported	Provider is required to update or confirm information every three years from credentialing date

Provider Classification	Reporting Mechanism	Update Frequency
Provider Taxonomy	Provider self-reported and health plan validated from NPPPES	Provider is required to update or confirm information every three years from credentialing date
Degree Attained (e.g., MD, RN, etc.)	Provider self-reported and health plan validated from DCCA Professional Vocational Licensing	Provider is required to update or confirm information every three years from credentialing date
Licenses and Certifications for Individuals and/or Facilities	Provider self-reported and health plan validates from DCCA Professional Vocational Licensing	Provider is required to update or confirm information every three years from credentialing date

Provider indicators: HSAG asked each health plan to specify whether its provider data system included fields for the following provider indicators: PCP, Prenatal Care Providers, BH Providers, HCBS Providers, Active/Inactive Providers, Telehealth Providers, and SUD Providers, including those offering MAT. Table 3-88 details 'Ohana CCS' reported responses and additional information regarding provider indicators.

Table 3-88—'Ohana CCS Provider Indicators

Provider Indicators	In Data System?	If Yes, Methods for Classifying Providers
PCPs	Yes	All providers with a provider specialty of Family Practice, Internal Medicine, Geriatrics, or Pediatrics
Behavioral Health Providers	Yes	All provider with a provider specialty of Psychologist, Psychiatrist, BH APRN-Rx, LCSW, LMFT, LMHC, Community Health Provider, or Representative Payee
SUD Treatment Providers, including providers offering MAT	Yes	All providers with a provider specialty of Substance Abuse or Behavioral Health Facility
Active/Inactive Providers	Yes	In Xcelys claims processing software, these providers are listed as active if they are participating in network and active in claims submission
Telehealth Providers	Yes	In Xcelys claims processing software, these providers are listed under Telemedicine field
PCPs	Yes	All providers with a provider specialty of Family Practice, Internal Medicine, Geriatrics, or Pediatrics
Behavioral Health Providers	Yes	All provider with a Provider Specialty of Psychologist, Psychiatrist, BH APRN-Rx, LCSW, LMFT, LMHC, Community Health Provider, or Representative Payee

Providers accepting new patients: 'Ohana CCS confirmed that its provider data system included fields to identify providers accepting new patients for all provider types and specialties.

Panel capacity: ‘Ohana CCS confirmed that its provider data system did not include fields to identify a provider’s panel capacity.

Use of single case agreements: ‘Ohana CCS reported that SCAs are agreements made with participating providers who require enhanced rates on case-by-case bases (e.g. adult foster care homes, DME), and these agreements are also made with nonparticipating providers such as out-of-state providers who service ‘Ohana CCS’ Medicaid population based on a negotiated rate per case. These agreements are created per approved authorization for services and pertain to only one member at a time. The period during which these agreements are valid is usually the length of time approved under the authorization. SCAs were tracked and monitored via ‘Ohana CCS’ internal SharePoint request system.

Provider network monitoring: ‘Ohana CCS monitored the adequacy of its provider network on a quarterly basis and reported to the State per the established contract standards for time, distance, and minimum provider criteria. ‘Ohana CCS used GeoAccess reports and Quest Analytics software for all adequacy analysis and mapping of providers.

Health plans’ provider data verification and cleaning: ‘Ohana CCS validated provider information through Veda, which conducted quarterly reviews. A quarterly report was received via email from the Provider Network team with underlying data from Veda’s quarterly reviews. ‘Ohana CCS reviewed providers’ past submissions to validate the data provided. If there was nothing on file, ‘Ohana CCS would conduct an outbound call to providers to validate, and if the information on file was correct, the next step was to submit a request to the Provider Network team to ask that the information be unsuppressed. If action was required, ‘Ohana CCS would submit a PLF to have the provider information updated in Xcelys.

Communicating provider network information to members: Provider information for ‘Ohana CCS was shared with Medicaid members via the Find a Provider tool on ‘Ohana CCS’ website, or the online provider directory. Members were also able to request a hardcopy of the provider directory via ‘Ohana CCS customer service representatives.

Strengths

‘Ohana CCS maintained detailed data regarding provider classifications (e.g., provider type, specialty, network participation, etc.) and provider indicators (e.g., PCP, SUD treatment providers, prenatal care providers) and reported multiple methods for updating, verifying, and cleaning provider data. ‘Ohana CCS also used multiple methods for monitoring its provider network and communicating provider network information to members and maintained data regarding new patient acceptance for all provider types and specialties.

Areas for Improvement

‘Ohana CCS did not collect data regarding provider panel capacity for any provider types or specialties.

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 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. Twelve agencies were contracted to complete the BHAs and submit them to 'Ohana CCS. 'Ohana CCS elected to use six standard and nine nonstandard supplemental data sources for MY 2021 performance measure reporting. No concerns were identified, and all standard and nonstandard data sources were approved to use for HEDIS MY 2021 performance 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 Hospitalization for Mental Illness* and *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* rates for ages *6–17 Years* and *65 and Older,* as well as *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 denominators were too small (<30) 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 3-89. 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[3-22] for HEDIS MY 2021. 'Ohana CCS met or exceeded the established target for one of the measure rates.

[3-22] *Ambulatory Care—ED Visits—Total, Ambulatory Care—Outpatient Visits—Total,* and *Mental Health Utilization—Any Service.*

Table 3-89—'Ohana CCS' HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Ambulatory Care—Total (per 1,000 Member Months)				
*ED Visits—Total**	56.40	48.70	-13.65%	★
Outpatient Visits—Total	240.63	212.30	-11.77%	NC
Mental Health Utilization				
Inpatient	8.71%	8.08%	-7.23%	NC
Intensive Outpatient or Partial Hospitalization	5.04%	3.77%	-25.20%	NC
Outpatient	71.76%	110.40%	53.85%	NC
ED	1.16%	1.84%	58.62%	NC
Telehealth	56.41%	57.82%	2.50%	NC
Any Service	83.92%	111.74%	33.15%	NC

Cells highlighted yellow indicate that 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.
[1] MY 2021 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 3-90. Eleven measure rates within this domain reported a relative improvement of more than 5 percent in HEDIS MY 2021, six of which showed a relative improvement of more than 20 percent. Additionally, 14 measure rates ranked at or above the 50th percentile, five of which met or exceeded the 75th percentile and eight of which met or exceeded the 90th percentile. Conversely, five measure rates ranked below the 50th percentile, three of which fell below the 25th percentile. Additionally, four measure rates in this domain had a relative decline of more than 10 percent in HEDIS MY 2021. 'Ohana CCS met or exceeded the HEDIS MY 2021 MQD established Quality Strategy for eight measure rates in this domain.

Table 3-90—'Ohana CCS' HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Adherence to Antipsychotic Medications for Individuals with Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	68.89%	69.65%	1.10%	★★★★
Antidepressant Medication Management				

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Effective Acute Phase Treatment	47.02%	51.69%	9.93%	★
Effective Continuation Phase Treatment	33.33%	40.68%	22.05%	★★★
Behavioral Health Assessment				
BHA Completion Within 14 Days of Enrollment (Within Standard)	37.41%	37.21%	-0.53%	NC
BHA Completion Within 15–30 Days of Enrollment (Not Within Standard)	23.26%	24.70%	6.19%	NC
BHA Completion within 31-60 Days of Enrollment (Not Within Standard)	10.72%	7.97%	-25.65%	NC
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence				
7 Day Follow-Up—13–17 Years	NA	NA	—	NC
7 Day Follow-Up—18+ Years	17.46%	19.70%	12.83%	★★★★
7 Day Follow-Up—Total	17.46%	19.70%	12.83%	★★★★
30 Day Follow-Up—13–17 Years	NA	NA	—	NC
30 Day Follow-Up—18+ Years	26.98%	30.54%	13.19%	★★★★
30 Day Follow-Up—Total	26.98%	30.54%	13.19%	★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	48.84%	69.79%	42.90%	★★★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	47.68%	69.91%	46.62%	★★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	69.65%	88.29%	26.76%	★★★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	68.12%	88.72%	30.24%	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	72.00%	72.73%	1.01%	★★★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	71.69%	71.97%	0.39%	★★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	88.47%	88.94%	0.53%	★★★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	87.87%	88.12%	0.28%	★★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation—Total—13–17 Years	NA	NA	—	NC
Initiation—Total—18+ Years	41.13%	35.33%	-14.10%	★
Initiation—Total—Total	41.13%	35.33%	-14.10%	★

Measure	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	Relative Difference	MY 2021 Performance Level[1]
Engagement—Total—13–17 Years	NA	NA	—	NC
Engagement—Total—18+ Years	13.06%	10.00%	-23.43%	★★
Engagement—Total—Total	13.06%	10.00%	-23.43%	★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by the MQD.
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.
[1] MY 2021 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. Three of the 14 measure rates (15.0 percent) ranked at or above the 75th percentile but below the 90th percentile, and eight of the 14 measure rates (40.0 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 2021.

Conversely, four measure rates (20.0 percent) fell below the 25th percentile, suggesting opportunities for improvement. HSAG recommends that 'Ohana CCS focus on improving performance related to the following measures with rates that fell below the 25th percentile for the CCS population:

- Behavioral Health
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—18+ Years* and *Initiation—Total—Total*

Validation of Performance Improvement Projects

In CY 2022, the MQD selected two new PIPs—*Behavioral Health Coordination* and *7-Day Follow-up After Emergency Department Visit for Mental Illness (FUM)* for 'Ohana CCS to complete. For the CY 2022 submission, the health plan progressed to the Design and Implementation stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The health plan will be assessed for improvement in outcomes (Step 9) in the next validation cycle.

Table 3-91 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-91—CY 2022 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design and Implementation Stage (Steps 1 through 8)	07/01/2021 to 09/30/2021	Baseline
7-Day Follow-up After Emergency Department Visit for Mental Illness	PIP Design and Implementation Stage (Steps 1 through 8)	CY 2021	Baseline

The focus of the nonclinical *Behavioral Health Coordination* PIP is to integrate care between the DOH Behavioral Health Services Administration divisions, CCS, and the QI Health Plans. This includes developing an infrastructure to streamline communication, information sharing, and continuity and coordination of care across agencies that provide services for a population with severe persistent mental illness, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by the MQD in consultation with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG.

The focus of the clinical *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP is to improve member health outcomes by increasing the rate of seven-day outpatient follow-up encounter post ED visit for mental illness. The performance indicator for this PIP is based on the HEDIS *FUM* measure.

Findings

Table 3-92 illustrates the validation results for the two PIPs submitted by ‘Ohana CCS for CY 2022 validation.

Table 3-92—CY 2022 PIP Validation Results for ‘Ohana CCS

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	93%	100%	*Met*
7-Day Follow-up After Emergency Department Visit for Mental Illness	100%	100%	*Met*

For the *Behavioral Health Coordination* PIP, ‘Ohana CCS received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 93 percent for overall evaluation elements across all steps completed and validated.

For the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP, ‘Ohana CCS received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated

Design (Steps 1-6)

Behavioral Health Coordination

‘Ohana CCS met nine of the 10 evaluation elements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD. The MQD held workgroup sessions with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. ‘Ohana CCS documented the PIP design accurately and as discussed during the workgroup meetings. ‘Ohana CCS’ data collection process as documented appeared methodologically sound; however, the data collection process was not comprehensive at the time of the PIP submission. ‘Ohana CCS was yet to define its processes to capture the denominator data for all the trigger events identified in Indicator 1. Additionally, the data sharing processes with HMSA and DOH Behavioral Health Services Administration divisions were to be determined.

7-Day Follow-up After Emergency Department Visit for Mental Illness ‘Ohana CCS met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by the MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. ‘Ohana CCS’ Aim statement set the focus of the PIP and the framework for data collection and analysis of results. ‘Ohana CCS clearly defined the eligible population and the performance indicator, which aligned with the HEDIS specifications. ‘Ohana CCS’ data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

‘Ohana CCS reported the baseline rates as available for the two performance indicators. ‘Ohana CCS documented its quality improvement efforts, which included participating in workgroup meetings with partnering agencies to discuss data sharing and identify the gaps in information needed by the health plans and DOH agencies.

7-Day Follow-up After Emergency Department Visit for Mental Illness ‘Ohana CCS accurately reported the baseline numerator, denominator, and percentage rate for the performance indicator. ‘Ohana CCS conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes.

Analysis of Results

Table 3-93 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-93—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 55 D: 517	10.6%		
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 696 D: 5,660	12.3%		

N–Numerator D–Denominator

The baseline rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 10.6 percent. The health plan documented that the data collection processes for a few of the trigger events (care transitions, a child who opts out of receiving health services, and shared members who have recently turned 18 years of age) were yet to be determined at the time of PIP submission. Additionally, only formal reviews were included in the baseline data.

The baseline rate for the percentage of shared members whose data were actively shared with the partner agencies during the measurement period was 12.3 percent. The health plan indicated that it had processes in place for actively sharing data via electronic data exchange with KFHP QI on a monthly basis and with AlohaCare QI and UHC CP QI on a quarterly basis. The process of data exchange with HMSA QI stopped over two years ago; therefore, HMSA QI members were not accounted for in the numerator of Indicator 2. The frequency of data sharing with DOH agencies was not defined.

Table 3-94 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-94—Performance Improvement Project Outcomes for the *7-Day Follow-up After Emergency Department Visit for Mental Illness*

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (07/01/2022–09/30/2022)	Sustained Improvement
1. Percentage of ED visits for members (18+ years of age) with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within seven days of the ED visit	N: 316 D: 452	69.9%		

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of ED visits for members (18+ years of age) with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit within seven days of the ED visit was 69.9 percent. The health plan will be assessed for statistically significant improvement in the performance indicator rate in the next annual submission.

Barriers/Interventions

A health plan's success in achieving significant improvement in PIP outcomes is strongly influenced by the improvement strategies and interventions implemented during the PIP. As part of the PIP validation process, HSAG reviewed the interventions documented by the health plans for appropriateness to the barriers identified and the timeliness of the implementation of the interventions.

Table 3-95 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-95—Interventions Implemented/Planned for 'Ohana CCS PIPs

PIP Topic	Barriers	Interventions
Behavioral Health Coordination	1. Identifying data sharing and standardization of data. No data exchange agreement is in place currently. 2. Identifying gaps in data and workflow amongst health plans and CCS.	1. Drafting and executing MOUs with the partnering agencies regarding data sharing.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*
7-Day Follow-up After Emergency Department Visit for Mental Illness	ED facility is too busy, and it is not a priority for the facility to notify the health plan of member's visit to the ED.	Educate ED facilities that are willing to work in collaboration with the 'Ohana CCS PIP team on the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP and establish rapport to work toward the common goal of ED utilization reduction.

* The documented interventions are required by the MQD.

Strengths

- For both PIPs, 'Ohana CCS received an overall *Met* validation status.
- For the *Behavioral Health Coordination* PIP, the health plan had initiated collaborative discussions with the partnering agencies for data sharing and combined reviews.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the reported baseline data were not comprehensive, as they did not include all the trigger events and data sharing information with all the partnering agencies.

Recommendations

Based on the validation of each PIP, HSAG has the following recommendations:

- The health plan should continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP:
  - The health plan should document its progress toward implementing the interventions and expanding the data sharing efforts with all the partnering agencies.
  - The baseline data for the performance indicators should be updated as the health plan determines the information sharing and data collection processes for all the trigger events and with all the partnering agencies.
  - Even though the PIP measurement periods are based on the third quarter in a calendar year, the health plan should collect the performance indicators' data on a quarterly basis and report quarterly data in Step 7 of the PIP Submission Form.
  - The health plan should capture any informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
- The health plan should update Step 3 and Step 5 of the PIP Submission Form with any changes made to the performance indicator specifications; for example, any changes to the combined review trigger events that were approved by the MQD should be updated in the next annual submission. The health plan should continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- The health plan should have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- The health plan must address the validation feedback associated with any *Met* score and *Partially Met* comments in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and the MQD throughout the PIP process to address any questions or concerns.

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 mixed performance across the four EQR activities. While 'Ohana CCS has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on certain compliance standards and outcome and process measures showed room for improvement.

'Ohana CCS' performance during the 2022 compliance review was average, meeting or exceeding the statewide compliance score for four of the eight standards. 'Ohana CCS achieved 100 percent compliance in four standards; however, the scores in the remaining four standards were all below the statewide averages for those standards. 'Ohana CCS was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

'Ohana CCS maintained robust systems for updating, verifying, storing, and sharing provider network data in accordance with State expectations. HSAG's CY 2022 NAV findings suggest that 'Ohana CCS' current provider network data systems and processes, as reported by the health plan in the PDSQ, are sufficient to support future NAV activities.

Overall, nearly three-quarters (70.0 percent) of 'Ohana CCS' measure rates ranked at or above the 50th percentile, with four measure rates (40.0 percent) falling below the 25th percentile. 'Ohana CCS should address performance in the Behavioral Health domain, specifically the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—18+ Years* and *Initiation—Total—Total* performance measures. Overall, nine of the MQD Quality Strategy targets were met in HEDIS MY 2021.

Finally, 'Ohana CCS progressed to the Design and Implementation stages of the two new PIP topics selected in CY 2022. The topics addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, 'Ohana CCS received an overall *Met* validation status. The reported baseline data were not comprehensive, as they did not include all the trigger events and data sharing information with all the partnering agencies.

For the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP, 'Ohana CCS received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The health plan will be assessed for improvement in outcomes in the next validation cycle.

4. Comparative Analysis of Health Plan Performance

Introduction

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

Compliance Monitoring Review

Table 4-1 summarizes the results from the 2022 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the eight compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

Table 4-1—Compliance Standards and Scores

	Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I.	Availability of Services	100%	100%	94%	97%	100%	96%	**98%**
II.	Assurances of Adequate Capacity and Services	100%	100%	50%	100%	100%	100%	**92%**
III.	Coordination and Continuity of Care	90%	95%	95%	90%	100%	100%	**95%**
IV.	Confidentiality	100%	100%	100%	100%	100%	100%	**100%**
V.	Coverage and Authorization of Services	92%	98%	100%	89%	100%	93%	**95%**
VI.	Enrollee Information	89%	89%	92%	84%	95%	86%	**89%**
VII.	Enrollee Rights and Protections	94%	100%	94%	94%	94%	93%	**95%**
VIII.	Grievance and Appeal System	97%	92%	98%	100%	98%	100%	**98%**
	Totals	**95%**	**96%**	**96%**	**93%**	**98%**	**95%**	**96%**

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

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure that their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. One standard was found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—Confidentiality. The Enrollee Information standard was identified as having the greatest opportunity for improvement, with a statewide compliance score of 89 percent, and all health plans having to implement corrective actions for

this standard. The Enrollee Rights and Protections standard was also identified as an area for improvement as five of the six health plans scored below the statewide compliance score for that standard.

UHC CP QI achieved the highest total compliance score and met or exceeded the statewide compliance score for seven of the eight standards. 'Ohana QI was the lowest-scoring plan, falling below the statewide score in five of the eight standards.

Total compliance scores were in the mid to high 90s for all health plans. These results suggest an overall high degree of compliance with State and federal managed care requirements. Following the 2022 compliance monitoring reviews, each health plan received a detailed written report of findings and recommendations and was required to develop and implement a CAP for all items that were not scored *Met*. The MQD and HSAG reviewed and approved the health plans' CAPs and will continue to provide follow-up monitoring until all identified deficiencies are corrected.

Validation of Network Adequacy

PNA Procedures and Instructions Review Findings

HSAG reviewed the MQD's Provider Network Adequacy Verification Manual, Version 3 (PNA Manual) as part of the CY 2022 NAV activity. During this review, HSAG noted that the MQD had very thorough instructions for the health plans regarding the completion of the quarterly provider network adequacy reports. MQD outlined detailed descriptions of the requested classification of providers, defining the rurality of providers, defining member populations, and the calculation of the driving time metrics.

HSAG noted that the PNA procedures document provided detailed step-by-step instructions for the health plans. This included the classification of providers to the correct PNA category and provider group using the provider type and specialty information. MQD provided this information in a straightforward and organized manner, although HSAG would recommend that additional clarification around the PCP classifications and the difference between PCP (Adult), PCP (Child), and Primary Care Providers may be helpful to readers.

The next step of the PNA procedures involved the identification of the geographic grouping for the provider practice by ZIP Code. For these geographical groupings, the MQD clearly defined that each provider practice must have an island rurality, which includes the name of the island and the rurality of the practice location on that island (e.g., Oahu—Urban or Hawaii—Rural). The MQD outlined specific procedures for identifying provider locations on the islands and how many locations may be counted in the PNA report per island, rurality, and provider type. In section 4.I.5.b of the PNA Manual, HSAG noted the following language: "Given that Psychiatric Nurse Practitioners may be counted in lieu of Psychiatrists in Rural Areas, the PNA Provider Categories 'Psychiatrists,' 'Nurse Practitioners (Psychiatric),' and 'Psychiatrists + Nurse Practitioners (Psychiatric)' may contain duplicates." HSAG recommends providing clarification if there may be duplication between "Psychiatrists" and "Nurse Practitioners (Psychiatric)" in rural areas or if the "Psychiatrists + Nurse Practitioners (Psychiatric)"

category should contain all providers in the "Psychiatrists" and "Nurse Practitioners (Psychiatric)" categories.

The PNA methodology described the process for identifying telehealth providers that health plans may include in the analyses to assess if telehealth is filling network gaps. The rules for when providers may be included in the telehealth analysis are clearly defined. The methodology notes: "Telehealth shall only be used to close network gaps for the provider types/types of services only for services that can be rendered via telehealth." It is unclear from the methodology if MQD has outlined if certain provider categories should not be considered for telehealth analysis. In section 4.L.13, the calculation for telehealth providers is described as follows: "If a provider is available to a member via telehealth, the member driving time to the provider shall be zero minutes, unless the member's telehealth claims typically include an origination site that is non-residential. In these cases, the driving time shall be based on the distance from the member's residence to the origination site."

HSAG recommends that the MQD provide additional clarification on this calculation and which members may be included. For example, should it only include members who do not have access based on the physical network? As written, HSAG understands this to mean that if 10 percent of the rural members of a health plan on Molokai had access to a provider within 30 minutes, but that health plan contracted with a telehealth provider in an urban area of Maui, then all rural members would have access to that telehealth provider, bringing the percentage of members with access in the physical/virtual network to 100 percent. If this was not the intent, HSAG recommends that the MQD review the language and update as needed.

The PNA methodology provided detailed guidelines for defining the member populations, including the appropriate reference date for determining age groups. The next step of the PNA methodology was the description of the calculation of the member driving time using geospatial software. The MQD provided the health plans with the specifications to use when determining member travel time. Additionally, the MQD noted that for the PCP (Adult) and PCP (Child) provider categories, the driving time should be based on the travel time to the member's assigned PCP, not just the nearest PCP. For all other provider categories, the driving time should be based on the shortest driving time from the member's residence to any provider. The PNA methodology also stated that only members in the population served should be counted. HSAG noted that the PNA_ALDF_v3.xlsx file had a clear description of the population served for each provider category and suggests that a reference to this list might be useful to the reader.

The final sections of the PNA methodology provided detailed information to the health plans on how to fill out the Aggregate Level Data File (ALDF), Provider Level Data File (PLDF), and Member Level Data File (MLDF). The instructions for the ALDF included instructions for determining the number of providers meeting the contract ratio standards, which include calculating the number of members attributed or receiving services from the providers at the provider level.

The health plans used the MLDF and PLDF to report more detailed information about the members and providers, respectively, included in the analysis. These data supported and informed the summary information provided in the ALDF.

In summary, after a thorough review of the PNA methodology and the review of the data submitted to HSAG by the health plans, HSAG proposes the following recommendations for moving forward with future PNA analyses:

- HSAG noted that data submitted by the health plans for the PNA analysis did not completely align with the instructions in the PNA methodology. HSAG understands that the MQD is continuing to collaborate with the health plans on the quarterly data submission process and understanding of the PNA instructions. HSAG recommends that the MQD continue this process to educate the health plans to ensure a seamless and efficient process in the future.
- As noted throughout Section 3 in this report, HSAG recommends that the MQD continue to refine the PNA procedures and instructions manual with edits for clarity that may assist the user. Some examples include:
  - Additional clarification around the PCP classifications and the difference between PCP (Adult), PCP (Child), and Primary Care Providers.
  - Additional clarification around driving time calculations with telehealth providers and when telehealth providers may be used to fill gaps in health plans' ability to meet the network adequacy standards.
- In reviewing the ALDFs submitted by the health plans, HSAG noted some discrepancies in how the number of members in the population served was being reported. HSAG recommends providing additional guidance to the health plans confirming how the number of members in the population served should be identified. For example, HSAG would expect that the number of members served for the physical specialists with a population served of adults (21 years and older) would be the same member count across specialties for each health plan. However, HSAG noted that some health plans reported a varying number of members served.

Provider Data Structure Questionnaire Findings

HSAG distributed the MQD-approved questionnaire to each health plan on August 11, 2022, requesting qualitative responses for 10 questionnaire elements and asking each health plan to provide supplemental documentation supporting its responses (e.g., data layouts or sample reports). All health plans participated in the questionnaire process and responded to HSAG's email requests for clarification, although these responses were self-reported and HSAG did not validate them against additional data sources.

Provider data structure: Each health plan reported using various operating platforms and claims payment systems to house and structure provider data for state plan services. HSAG asked the health plans to supply a file layout supporting their data structure descriptions. All health plans supplied the requested documentation, although there was variation in the specificity and comprehensiveness of the supporting documentation. Table 4-2 presents details regarding where each health plan stores data within internal data systems, the data software and systems used to store the data, and how the provider data link to the health plan's claims system.

Table 4-2—Provider Data System Details Self-Reported by Health Plan

Health Plan	Health Plan's Data Storage System	Health Plan's Summary of Provider Data Linkage to Claims Data
AlohaCare	Cognizant TriZetto Software Group, Inc. (QNXT) Productions 5.8 R1.	Claims data within QNXT is linked to both billing and rendering providers using provider identification numbers (IDs) such as NPI and Taxpayer Identification Number (TIN).
HMSA	eVIPs and QNXT QI	eVIPs is used to store demographic, credentialing, contracting and plan participation data while QNXT is used to process claims.
Kaiser Provider Contracting	Kaiser Foundation Health Plan's (KFHP's) Provider Contracting Team manages provider data through its database and use of an Excel document.	Kaiser Permanente Claims Connect (Tapestry system) • Link claims to the correct Vendor, Provider, and Place of Service records using matching logic such as tax ID, NPI, etc. Together, these records drive various processes during auto adjudication, including contract selection and network selection. • Electronically loaded claims use ANSI data such as the provider's NPI, the vendor's NPI, or the vendor's tax ID to research and correct any matching errors identified. • If a matching record cannot be found, the system applies pend code for no Vendor, Place of Service, or Provider and claim is sent to the appropriate team to resolve. • When claims pend, the ANSI data are used to search for and build the records needed to resolve the claim.
Kaiser HPMG	KFHP subcontracts with the Hawaii Permanente Medical Group (HPMG). HPMG collects and maintains provider information in a SAAS-based (Web based), Human Resource and Payroll system hosted by UKG, dba Ultimate Software. Monthly reports are pulled from UKG by HPMG Analytics to combine with operational data.	Kaiser Permanente Claims Connect (Tapestry system) • Link claims to the correct Vendor, Provider, and Place of Service records using matching logic such as tax ID, NPI, etc. Together, these records drive various processes during auto adjudication, including contract selection and network selection. • Electronically loaded claims use ANSI data such as the provider's NPI, the vendor's NPI, or the vendor's tax ID to

Health Plan	Health Plan's Data Storage System	Health Plan's Summary of Provider Data Linkage to Claims Data
		research and correct any matching errors identified. • If a matching record cannot be found, the system applies pend code for no Vendor, Place of Service or Provider and claim is sent to the appropriate team to resolve. • When claims pend, the ANSI data are used to search for and build the records needed to resolve the claim.
'Ohana QI	Provider data structure includes the following: Salesforce, iCertis, IBPS PLFs, and Xcelys. Provider's information is entered into Salesforce that houses the provider's demographics, health plan's outreach, and retrieval of the documents needed for credentialing, and provide load purposes. iCertis is the health plan's contract management system where it creates, manages, and executes contracts. IBPS is the health plan's provider data management system that takes the information received from providers and transfers it into the core processing system Xcelys. Information obtained from the providers is transcribed into the PLF in preparation for provider load submission into Xcelys.	Xcelys is where providers are loaded, and claims are processed. The provider's information is loaded under a unique provider identification number tied to each individual or facility. Xcelys houses the provider data, which are linked to claims processing and contract reimbursement.
'Ohana CCS	Provider data structure includes the following: Salesforce, iCertis, IBPS Provider Load Forms, and Xcelys. Provider's information is entered into Salesforce that houses the provider's demographics, health plan's outreach, and retrieval of the documents needed for credentialing, and provide load purposes. iCertis is the health plan's contract management system where it creates, manages, and executes contracts. IBPS is the health plan's provider data management system that takes the information received from providers and	Xcelys is where providers are loaded, and claims are processed. The provider's information is loaded under a unique provider identification number tied to each individual or facility. Xcelys houses the provider data, which are linked to claims processing and contract reimbursement.

Health Plan	Health Plan's Data Storage System	Health Plan's Summary of Provider Data Linkage to Claims Data
	transfers it into the core processing system Xcelys. Information obtained from the providers is transcribed into the PLF in preparation for provider load submission into Xcelys.	
UHCCP	Demographic and contractual data is stored within the UnitedHealthcare source system NDB.	Data subsequently feeds on a nightly basis to CSP Facets, which is the claims platform used for processing network provider claims. The data model for the Facets system can be provided for the provider data in particular.

Delegated services: Each of the health plans providing Medicaid healthcare services reported delegating some services (i.e., contracting all or part of the provision of selected services, such as mental health services) to another entity. Each health plan also reported multiple methods of performing oversight of the delegated provider networks, including identification of specific policies and procedures related to subcontractor oversight. Table 4-3 summarizes, by health plan, the delegated provider type/service, delegated entity name, and the frequency with which the health plan received provider data from the delegated entity at the time of the questionnaire response.

Table 4-3—Summary of Delegated Service Types and Entity Name by Health Plan and Frequency of Provider Data Receipt

Health Plan	Delegated Provider Type/Service	Delegated Entity Name(s)	Frequency of Provider Data Receipt
AlohaCare	Non-emergency Transportation Services	IntelliRide	Provider data/rosters are shared monthly and as needed to maintain AlohaCare QI's provider data using custom data layout. Includes both new providers and recent terminations.
	PBM	IngenioRx	Provider data/rosters are shared monthly and as needed to maintain AlohaCare QI's provider data using custom data layout. Includes both new providers and recent terminations.
	Online Behavioral Health/Telehealth Services	Amwell	Provider data/rosters are shared monthly and as needed to maintain AlohaCare QI's provider data using custom data layout. Includes both new providers and recent terminations.

Health Plan	Delegated Provider Type/Service	Delegated Entity Name(s)	Frequency of Provider Data Receipt
HMSA	Vision	EyeMed	The vendor supplies a bi-weekly network file to HMSA QI in Excel format.
	Pharmacy	CVS	The vendor supplies: • Daily HMSA QI Medicaid State Roster file. • Weekly HMSA QI add/term report of Medicaid directories. • Weekly report of Medicaid directory file.
Kaiser Provider Contracting	Case Management Services	Community Care Management Agency	Forms are completed when there is a new KFHP QI member assessment.
Kaiser HPMG	Provider Type • MD – Physician • DO-Physician Osteopath • Certified Nurse—Midwife • Physician Assistant • Podiatrist • Board Certified Behavior Analyst • Psychologist Service • Addiction Medicine • Allergist • Anesthesiologist • Cardiologist • Cardiovascular Medicine • Critical Care Medicine • Dermatologist • Emergency Medicine • Endocrinologist • Family Practice • Gastroenterologist	Hawaii Permanente Medical Group	HPMG notifies KFHP QI of changes in the network through monthly reports.

Health Plan	Delegated Provider Type/Service	Delegated Entity Name(s)	Frequency of Provider Data Receipt
	• Geneticist • Gerontologist • Hematology and Oncology • Infectious Diseases • Internal Medicine • Nephrologist • Neurologist • Obstetrician And Gynecologist • Occupational Medicine • Ophthalmology • Optometrist • Orthopedist		
	• Other • Pain Control • Pathology • Pediatrician • Podiatrist • Psychiatrist • Psychologist • Radiology • Rheumatologist • Surgery • Surgery—Cardiovascular • Surgery—Neurology • Surgery—Plastic • Surgery—Vascular • Urologist		
‘Ohana QI	Non-Emergent Transportation	IntelliRide	Quarterly.
	Pharmacy Benefit Services	CVS	Daily via claims received.

Health Plan	Delegated Provider Type/Service	Delegated Entity Name(s)	Frequency of Provider Data Receipt
	Vision Services	Premier Eye Care	Monthly rosters are received with provider added, termed, and in network currently.
	Audiology Services	HearUSA	Rosters presented to health plan during monthly calls with HearUSA.
	PCP/Specialist within Hawaii Pacific Health Provider Network	Hawaii Pacific Health (HPH)	As HPH identifies providers added to their network, their representative will send the Provider Data Management Team and update spreadsheet.
	Community Case Management Agencies	• Above and Beyond Case Management • Absolute Care Management Services • Blue Water Resources • Case Management Professionals • Hale Makua Home Health Agency • HI Secure Care Case Management • Kinaole Case Management • Lokahi Case Management • Quality Case Management • Residential Choices	Annually.
‘Ohana CCS	Non-Emergent Transportation	IntelliRide	Quarterly
	Pharmacy Benefit Management	CVS	Daily via claims received
	Community Based Case Management	• Aloha House • Care Hawaii • Community Empowerment Resources • Helping Hands Hawaii • Hope, Inc. • Institute for Human Services (IHS) • Kokua Kalihi Valley Comp Family Services	Annually, unless the agency has a finding with a CAP, then it is much more frequently.

Health Plan	Delegated Provider Type/Service	Delegated Entity Name(s)	Frequency of Provider Data Receipt
		• Kalihi Palama Health Clinic • Mental Health Kokua • North Shore Mental Health Inc • State of Hawaii Dept of Health • Waianae Coast Community Mental Health – Hale Naau Pono	
	Behavior Health Providers within Hawaii Pacific Health Provider Network	Hawaii Pacific Health	As HPH identifies providers added to their network, their representative will send the Provider Data Management Team and update spreadsheet.
UHCCP	Behavioral Heath	Optum BH	Daily updates via NDB proprietary interchange.
	Pharmacy	Optum RX	Daily via Optum Rx NCPDP Network file.
	Transportation	ModivCare	Daily via ModivCare.

Provider Classification Data Collection and Maintenance: Each health plan submitted information on selected provider categorization fields, some supplying corresponding data dictionaries with their questionnaire responses. All health plans reported including the following provider classifications in their provider data, with data values self-reported by the contracted providers:

- Provider type
- Provider specialty
- Provider taxonomy
- Degree attained (e.g., MD, RN)
- Licenses and Certifications for individuals and/or facilities

The health plans use a variety of methods to confirm and validate the self-reported information.

Provider indicators: HSAG asked each health plan to specify whether its provider data system included fields for the following provider indicators: PCP, Prenatal Care Providers, BH Providers, HCBS Providers, Active/Inactive Providers, Telehealth Providers, and SUD providers, including those offering MAT. The questionnaire prompt also gave health plans the opportunity to supply information on other indicator fields maintained in their data systems. All health plans reported having data fields present to indicate the following provider types:

- PCPs
- Active/Inactive Providers
- Telehealth Providers

The health plans used a variety of methods to classify these types of providers in their data systems.

Providers accepting new patients: HSAG asked each health plan whether its provider data system included fields identifying providers accepting new patients. All health plans reported using providers' self-reported information regarding whether the provider accepted new patients. The provider types for which new patient acceptance was monitored varied between the plans.

Panel capacity: HSAG asked each health plan whether its provider data system included fields to capture provider panel capacity (i.e., the number of members that the provider is able to serve). Only two health plans, AlohaCare QI and UHCCP QI, reported capturing this information in their provider data systems. AlohaCare reported only maintaining data related to panel capacity for PCPs, and this information was self-reported by the provider. UHCCP QI reported maintaining data related to provider panel capacity for PCPs, Specialists, and OB/GYNs. This information is also self-reported by the provider.

Use of single case agreements: SCAs and LOAs are a type of contracting arrangement that provides individuals with needed services that are not available within a health plan's current provider network. These arrangements allow a provider not currently enrolled with a health plan's network to provide services on a limited basis (e.g., to serve a single member or only members with a specific health condition).

All four health plans reported using SCAs/LOAs to contract providers to render specific services, describing applicable scenarios where agreements were used, and providing descriptions and/or copies of policies and procedures for dealing with requests for out of network coverage. All four health plans described how these agreements were tracked in their respective billing systems.

Provider network monitoring: HSAG asked each health plan to describe its internal monitoring of provider network adequacy and members' ability to access necessary services. All health plans reported various methods of monitoring provider network adequacy including the use of the following tools and methods:

- PNA reporting
- CAHPS surveys
- Timely access reporting
- Appeals and grievances

Health plans' provider data verification and cleaning: When asked to describe their provider data verification and cleaning efforts, including credential verification, address standardization, and telephone number verification, the health plans reported the following strategies:

- Internal auditing and validation
- Credentialing and recredentialing verification through IntelliCred, internal credentialing teams and committees, NPPES, and/or NCQA

Communicating provider network information to members: All health plans reported offering an online provider directory through which members could identify participating providers. Members could access this provider information via the health plan's website, and each health plan reported that it had a member services phone number for members to call to inquire about any provider information. Additionally, the health plans indicated in their questionnaire responses that they offered the option of a paper copy of the directory by request, or via a printable handbook on their website.

In summary, after the thorough review of the health plans' submitted PDSQ responses and supplemental documentation, HSAG proposes the following recommendations for moving forward with future NAV analyses:

- The MQD could consider requesting documentation of the health plans' internal verification and oversight practices to ensure the accuracy of their provider data.
- The MQD could consider requesting copies of the health plans' policies, procedures, and recent reports for monitoring provider data received from vendors, including information demonstrating how frequently provider data anomalies are identified and corrected. The MQD's review of the health plans' documentation will allow the MQD to verify that each health plan is routinely validating vendor data and updating information found in the corresponding online provider directory. The MQD should work with each health plan to determine the appropriate frequency of vendors' data submissions, overall data reviews, and a timeline for subsequent investigations and data reconciliation.
- The MQD could consider requesting copies of the health plans' documentation reflecting the use and oversight of SCAs or LOAs to verify that the plans are not using SCAs or LOAs in lieu of providing robust networks of providers.

Validation of Performance Measures—HEDIS Compliance Audits

NCQA HEDIS Compliance Audits

Table 4-4 compares each QI health plan's compliance with each HEDIS IS standard reviewed during the MY 2021 NCQA HEDIS Compliance Audit.

Table 4-4—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 2021 measure rates and their performance relative to the NCQA national Medicaid Quality Compass HEDIS MY 2020 percentiles, where applicable. Please note there are no national benchmarks for the LTSS measures; therefore, these are not displayed. 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 4-5 displays the Access and Risk-Adjusted Utilization measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-5—Comparison of HEDIS MY 2021 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	41.87 —	22.09 —	36.75 —	91.62 —	46.28 —
65+ Years	138.55 —	94.66 —	88.05 —	155.76 —	121.71 —
Total	50.84 —	26.49 —	40.56 —	102.84 —	66.62 —
Plan All-Cause Readmissions					
*Index Total Stays—Observed Readmissions—Total**	8.90% ★★★	7.72% ★★★★★	7.56% ★★★★★	9.61% ★★★	11.73% ★
Expected Readmissions—Total	9.95% —	9.44% —	9.85% —	11.65% —	11.06% —
*Index Total Stays—O/E Ratio—Total**	0.89 —	0.82 —	0.77 —	0.83 —	1.06 —

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, three of five QI health plans met the MQD's established target for the one measure with an MQD Quality Strategy target for HEDIS MY 2021 (*Heart Failure Admission Rate—Total*). For the *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* rate, four of five QI health plans (AlohaCare QI, HMSA QI, KFHP QI, and 'Ohana QI) ranked at or above the 50th percentile. Of note, HMSA QI and KFHP QI met or exceeded the 90th percentile. Conversely, UHC CP QI ranked below the 25th percentile.

Children's Preventive Health

Table 4-6 displays the Children's Preventive Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-6—Comparison of HEDIS MY 2021 Children's Preventive Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Child and Adolescent Well-Care Visits					
3–11 Years	49.63% ★★	56.18% ★★★	41.63% ★	45.60% ★★	41.74% ★
12–17 Years	46.03% ★★★	56.36% ★★★★	42.49% ★★	39.77% ★★	36.51% ★
18–21 Years	16.04% ★	26.69% ★★★	12.84% ★	16.76% ★	14.08% ★
Total	42.47% ★★	51.06% ★★★	36.94% ★	39.15% ★	35.16% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Childhood Immunization Status					
Combination 2	37.47% —	63.26% —	74.44% —	50.36% —	53.04% —
Combination 3	35.77% ★	61.31% ★	72.10% ★★★	48.66% ★	51.58% ★
Combination 4	35.52% —	60.83% —	72.10% —	48.42% —	51.34% —
Combination 5	30.66% —	51.58% —	69.86% —	42.34% —	44.53% —
Combination 6	25.55% —	46.72% —	62.73% —	40.39% —	40.15% —
Combination 7	30.41% ★	51.09% ★	69.86% ★★★★★	42.09% ★	44.53% ★
Combination 8	25.30% —	46.72% —	62.73% —	40.15% —	40.15% —
Combination 9	22.14% —	40.15% —	60.81% —	36.25% —	35.28% —
Combination 10	21.90% ★	40.15% ★★★	60.81% ★★★★★	36.01% ★★	35.28% ★★
DTaP	51.34% ★	69.34% ★	75.93% ★★★	51.82% ★	54.74% ★
Hepatitis A	67.64% ★	78.35% ★	85.30% ★★★	63.99% ★	67.88% ★
Hepatitis B	61.31% ★	75.91% ★	90.31% ★★★	69.10% ★	75.18% ★
HiB	65.94% ★	79.81% ★	79.98% ★	66.18% ★	71.53% ★
Influenza	46.47% ★★	55.47% ★★★	72.10% ★★★★★	51.58% ★★★	50.36% ★★
IPV	69.59% ★	78.59% ★	88.07% ★★	68.86% ★	72.75% ★
MMR	61.07% ★	79.08% ★	85.09% ★	65.21% ★	69.59% ★
Pneumococcal Conjugate	52.80% ★	69.59% ★	73.06% ★★	52.55% ★	55.47% ★
Rotavirus	56.45% ★	64.96% ★	84.45% ★★★★★	55.23% ★	59.61% ★
VZV	69.83% ★	78.10% ★	85.20% ★★	65.21% ★	68.86% ★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	59.57% ★★★	67.56% ★★★★	73.09% ★★★★★	51.86% ★★	49.58% ★★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	59.23% ★	72.86% ★★★	80.51% ★★★★	59.82% ★	52.88% ★

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by the MQD.
— 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, *Childhood Immunization Status—Combinations 2, 4, 6, 8,* and *9* were retired for HEDIS MY 2021; therefore, no benchmark comparisons were made. KFHP QI performed best among the health plans, with 10 measure rates ranking at or above the 50th percentile, one of which met or exceeded the 75th percentile and five of which met or exceeded the 90th percentile. UHC CP QI demonstrated the lowest performance among the health plans, with 16 of 19 measure rates that could be compared to benchmarks ranking below the 25th percentile.

Three measures (*Child and Adolescent Well-Care Visits—Total, Childhood Immunization Status—Combination 3,* and *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits*) within the Children's Preventive Health domain were associated with MQD Quality Strategy targets in HEDIS MY 2021. Four health plans (AlohaCare QI, HMSA QI, KFHP QI, and 'Ohana QI) met or exceeded the established targets for *Child and Adolescent Well-Care Visits—Total,* one health plan (KFHP QI) met or exceeded the target for *Childhood Immunization Status—Combination 3,* and two health plans (KFHP QI and UHC CP QI) met or exceeded the target for *Well-Child Visits in the First 30 Months of Life—First 15 Months—Six or More Well-Child Visits*.

Women's Health

Table 4-7 displays the Women's Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-7—Comparison of HEDIS MY 2021 Women's Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Cervical Cancer Screening					
Cervical Cancer Screening	53.77% ★★	57.11% ★★	67.36% ★★★★	43.55% ★	50.85% ★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	82.48% ★★	84.48% ★★	89.62% ★★★★	79.58% ★★	78.35% ★
Postpartum Care	77.62% ★★★	76.72% ★★★	84.62% ★★★★★	71.48% ★★	78.10% ★★★

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. Additionally, KFHP QI reached the MQD's established targets for all three measure rates in this domain.

'Ohana QI and UHC CP QI demonstrated the worst performance for the *Cervical Cancer Screening* measure, ranking below the 25th percentile. UHC CP QI also ranked below the 25th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate.

For the *Prenatal and Postpartum Care* measure rates, all QI health plans met the MQD's established targets except 'Ohana QI's and UHC CP QI's *Timeliness of Prenatal Care* rates. Of note, KFHP QI ranked at or above the 75th percentile for the *Timeliness of Prenatal Care* rate and at or above the 90th percentile for the *Postpartum Care* rate.

Care for Chronic Conditions

Table 4-8 displays the Care for Chronic Conditions measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-8—Comparison of HEDIS MY 2021 Care for Chronic Conditions Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHCCP QI
Comprehensive Diabetes Care					
HbA1c Testing	85.89% ★★★	84.63% ★★★	90.95% ★★★★★	87.35% ★★★★	92.46% ★★★★★
*HbA1c Poor Control (>9.0%)**	40.15% ★★★	39.76% ★★★	35.64% ★★★★	37.47% ★★★★	29.20% ★★★★★
HbA1c Control (<8.0%)	48.66% ★★★	48.05% ★★★	52.64% ★★★★	52.55% ★★★★	57.42% ★★★★★
Eye Exam (Retinal) Performed	53.28% ★★★	64.63% ★★★★★	55.12% ★★★	54.01% ★★★	63.26% ★★★★★
Blood Pressure Control (<140/90 mm Hg)	55.72% ★★	54.39% ★★	64.15% ★★★	53.28% ★★	69.59% ★★★★
Concurrent Use of Opioids and Benzodiazepines*					
18–64 Years	9.86% —	13.10% —	6.75% —	19.90% —	14.20% —
65+ Years	10.81% —	9.42% —	9.09% —	16.60% —	14.52% —
Total	9.98% —	12.90% —	7.11% —	19.14% —	14.33% —
Controlling High Blood Pressure					
18-64 Years	56.09% —	53.80% —	64.86% —	57.20% —	53.33% —
65-85 Years	53.54% —	55.38% —	73.00% —	61.49% —	73.15% —
Total (18-85 Years)	55.47% ★★★	54.05% ★★	67.02% ★★★★★	58.88% ★★★	63.75% ★★★★

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 Care for Chronic Conditions performance measure domain, UHC CP QI performed the best among the health plans, with all six measure rates that could be compared to benchmarks ranking at or above the 75th percentile, four of which ranked at or above the 90th percentile. Of note, KFHP QI ranked at or above the 50th percentile for all six measure rates, two of which ranked at or above the 75th percentile, and two of which ranked at or above the 90th percentile. Additionally, 'Ohana QI and AlohaCare QI ranked at or above the 50th percentile for five of the six measure rates and HMSA QI ranked at or above the 50th percentile for four of the six measure rates. Conversely, HMSA QI demonstrated the worst performance among the health plans, having two measure rates fall below the 25th percentile.

The five *Comprehensive Diabetes Care* measure indicators and *Concurrent Use of Opioids and Benzodiazepines—Total* measure indicator within the Care for Chronic Conditions domain were associated with an MQD Quality Strategy target in HEDIS MY 2021. UHC CP QI reached five of the established targets, KFHP QI reached four of the established targets, 'Ohana QI met two of the established targets, and HMSA QI met one established target. AlohaCare QI did not meet any of the established MQD targets.

Behavioral Health

Table 4-9 displays the Behavioral Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-9—Comparison of HEDIS MY 2021 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	24.32% ★	46.11% ★★	NA	NA	NA
7-Day Follow-Up—18–64 Years	22.28% ★	35.80% ★★★	45.04% ★★★★	54.96% ★★★★★	47.67% ★★★★
7-Day Follow-Up—65+ Years	NA	NA	NA	NA	NA
7-Day Follow-Up—Total	22.12% ★	38.48% ★★	49.69% ★★★★	53.15% ★★★★	47.37% ★★★
30-Day Follow-Up—6–17 Years	56.76% ★	67.22% ★★	NA	NA	NA
30-Day Follow-Up—18–64 Years	47.28% ★★	58.56% ★★★	63.36% ★★★	68.70% ★★★★	63.21% ★★★
30-Day Follow-Up—65+ Years	NA	NA	NA	NA	NA
30-Day Follow-Up—Total	48.23% ★	60.66% ★★★	67.70% ★★★★	67.13% ★★★	62.72% ★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment					
Initiation—Total—13–17 Years	36.36% ★	38.84% ★	NA	NA	NA
Initiation—Total—18+ Years	36.56% ★	37.64% ★	37.48% ★	39.97% ★	34.70% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Initiation—Total—Total	36.56% ★	37.67% ★	37.18% ★	39.92% ★	34.73% ★
Engagement—Total—13–17 Years	4.55% ★	12.40% ★★	NA	NA	NA
Engagement—Total—18+ Years	9.28% ★★	13.56% ★★	8.15% ★	11.45% ★★	8.84% ★
Engagement—Total—Total	9.18% ★	13.53% ★★	7.83% ★	11.42% ★★	8.88% ★
Screening for Depression and Follow-Up Plan					
12–17 Years	20.99% —	48.81% —	1.70% —	15.87% —	16.43% —
18–64 Years	12.86% —	27.28% —	7.56% —	7.86% —	7.65% —
65 Years and Older	20.91% —	29.20% —	9.16% —	23.27% —	27.74% —
18 Years and Older	13.73% —	27.40% —	7.71% —	11.61% —	14.81% —
Use of Pharmacotherapy for Opioid Use Disorder					
Total	51.36% —	50.91% —	62.16% —	50.70% —	45.78% —
Buprenorphine	30.86% —	33.88% —	59.46% —	22.54% —	23.43% —
Oral Naltrexone	0.99% —	1.09% —	2.70% —	0.35% —	0.82% —
Long-Acting, Injectable Naltrexone	0.00% —	0.36% —	0.00% —	0.00% —	0.27% —
Methadone	22.22% —	17.39% —	0.00% —	31.69% —	23.71% —

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, 10 measure indicator rates had MQD-established Quality Strategy targets. Four of five QI health plans (HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI) reached the established targets for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates. All five health plans did not have 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.* Three of five health plans (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 and were assigned a status of *NA.*

For *Initiation and Engagement of Alcohol or Other Drug Abuse Treatment—Initiation—Total—Total,* three of five QI health plans (HMSA QI, KFHP QI, and 'Ohana QI) met the MQD's established target

and one QI health plan (HMSA QI) met the target for the *Engagement—Total—Total* measure rate. Three of five health plans (HMSA QI, KFHP QI, and 'Ohana QI) did not have enough members in the eligible population for the *Initiation—Total—13–17 Years* and *Engagement—Total—13–17* measure indicators and were assigned a status of *NA.*

AlohaCare QI demonstrated the worst performance among the health plans, only reaching the established targets for four measure rates, and out of 13 measure rates that could be compared to national benchmarks, 12 rates fell below the 50th percentile, 10 of which fell below the 25th percentile.

Summary of MQD Quality Strategy Targets

Table 4-10 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 4-10—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	Not Met	Met	Not Met	Met
*Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total**	Not Met	Not Met	Not Met	Not Met	Not Met
Children's Preventive Health					
Child and Adolescent Well-Care Visits—Total	Met	Met	Met	Met	Not Met
Childhood Immunization Status—Combination 2	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 3	Not Met	Not Met	Met	Not Met	Not Met
Childhood Immunization Status—Combination 4	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 5	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 6	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 7	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 8	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 9	Not Met	Not Met	Not Met	Not Met	Not Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Childhood Immunization Status—Combination 10	Not Met	Not Met	Not Met	Not Met	Not Met
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Si	Not Met	Not Met	Met	Not Met	Met
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Tw	Not Met	Not Met	Not Met	Not Met	Not Met
Women's Health					
Cervical Cancer Screening	Not Met	Not Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Met	Met	Met	Not Met	Not 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	Met
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	Not Met	Not Met	Met	Not Met	Met
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	Not Met	Not Met	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	Met	Not Met	Met
*Concurrent Use of Opioids and Benzodiazepines—Total**	Not Met	Met	Met	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
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—Total	Not Met	Met	Met	Met	Not Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement—Total—Total	Not Met	Met	Not Met	Not Met	Not Met
Screening for Depression and Follow-Up Plan—18+ Years	Met	Met	Not Met	Not Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Total	Met	Not Met	Met	Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Buprenorphine	Met	Met	Met	Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Oral Naltrexone	Not Met	Not Met	Met	Not Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Long-Acting, Injectable Naltrexone	Not Met	Met	Not Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Methadone	Met	Not Met	Not Met	Met	Met
Total MQD Targets Met	**8**	**11**	**17**	**10**	**14**
Percent MQD Targets Met	**24.24%**	**33.33%**	**51.52%**	**30.30%**	**42.42%**

Validation of Performance Improvement Projects

Table 4-11 summarizes HSAG's key validation findings for the two PIPs conducted by the QI health plans.

Table 4-11—PIP Validation Findings for the QI Health Plans

Health Plan	Behavioral Health Coordination			Plan-All Cause Readmissions		
	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
AlohaCare QI	100%	100%	*Met*	100%	100%	*Met*
HMSA QI	100%	100%	*Met*	93%	100%	*Met*
KFHP QI	100%	100%	*Met*	100%	100%	*Met*
'Ohana QI	93%	100%	*Met*	93%	100%	*Met*
UHC CP QI	100%	100%	*Met*	100%	100%	*Met*

Table 4-12 summarizes HSAG's key validation findings for the two PIPs conducted by 'Ohana CCS.

Table 4-12—PIP Validation Findings for 'Ohana CCS

Health Plan	Behavioral Health Coordination			Follow–Up After Emergency Department Visit for Mental Illness		
	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
'Ohana CCS	93%	100%	*Met*	100%	100%	*Met*

CY 2022 was the first validation year for these PIPs. All the PIP topics were required by the MQD and address the CMS' requirements related to quality outcomes—specifically quality of, timeliness of, and access to care and services. The PIP topics are also in alignment with the goals and the objectives included in the MQD Quality Strategy. In addition to the PIPs, the MQD also encouraged the health plans to participate in a collaborative and work together toward the common goal of achieving improvement in access, quality, and timeliness of care through these PIPs. Moving forward, HSAG recommends that the MQD continue to engage with the health plans and DOH Behavioral Health divisions to ensure that progress is being made toward data sharing and an integrated care approach. The PIPs are submitted to the EQRO for annual validation; however, the MQD may require the health plans to provide an update on the status of their interventions on a quarterly basis. Any system barriers to implementing interventions should be addressed in a timely manner. The health plans should also continue to report to the MQD how they have implemented the lessons from the previous PIPs to improve the outcomes in the new PIPs. For the *Plan All-Cause Readmissions* PIP and the *Follow–Up After Emergency Department Visit for Mental Illness* PIP, the health plans may be encouraged to seek member input regarding barriers to accessing care.

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

Statewide Comparisons—QI Health Plans

Table 4-13 presents the 2022 top-box scores for each QI health plan and the QI Program aggregate.[4-1] Additionally, results comparing the QI health plans to the overall QI Program aggregate are displayed below.

Table 4-13—Comparison of 2022 QUEST Integration Adult CAHPS Results

	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	QI Program
Global Ratings						
Rating of Health Plan	59.8%	59.0%	62.9%	60.2%	68.1%	61.6%

[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.

	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	QI Program
Rating of All Health Care	56.0%	56.8%	60.9%	53.6%	68.1%	58.4%
Rating of Personal Doctor	64.1%	61.8%	64.1%	71.5%	63.0%	65.1%
Rating of Specialist Seen Most Often	70.6%	75.9%	62.9%	71.9%	70.0%+	70.1%
Composite Measures						
Getting Needed Care	79.2%	78.5%	79.6%	80.4%	77.8%+	79.2%
Getting Care Quickly	75.5%	71.8%	78.9%	77.5%	74.5%+	75.8%
How Well Doctors Communicate	90.7%	90.6%	90.6%	91.7%	88.1%	90.6%
Customer Service	83.9%	87.5%+	85.1%+	83.6%	83.6%+	84.7%
Individual Item Measure						
Coordination of Care	78.9%+	79.4%+	79.2%	88.5%	81.2%+	81.7%

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2021 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2021 NCQA adult Medicaid national averages.
↑ Indicates the score is statistically significantly higher than the QI Program aggregate.
↓ Indicates the score is statistically significantly lower than the QI Program aggregate.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Comparison of the QI Program aggregate and QI health plans' scores to the 2021 NCQA adult Medicaid national averages revealed the following summary results:

- The QI Program aggregate scored statistically significantly lower than the national average on five measures: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Coordination of Care*.
- AlohaCare QI did not score statistically significantly higher or lower than the national average on any of the measures.
- HMSA QI scored statistically significantly lower than the national average on two measures: *Rating of Personal Doctor* and *Getting Care Quickly*.
- KFHP QI did not score statistically significantly higher or lower than the national average on any of the measures.
- 'Ohana QI did not score statistically significantly higher or lower than the national average on any of the measures.
- UHC CP QI scored statistically significantly higher than the national average on one measure, *Rating of All Health Care*.

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

- AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and 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 4-14 presents the 2022 top-box scores for the Hawaii CHIP population.

Table 4-14—Comparison of 2022 CHIP CAHPS Results

Global Ratings	
Rating of Health Plan	72.3% ▼
Rating of All Health Care	68.9%
Rating of Personal Doctor	79.5%
Rating of Specialist Seen Most Often	71.8%+
Composite Measures	
Getting Needed Care	80.8%
Getting Care Quickly	83.1%
How Well Doctors Communicate	94.4% ▼
Customer Service	90.0%+
Individual Item Measure	
Coordination of Care	92.6%+

Cells highlighted in yellow represent scores that are at or above the 2021 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are below the 2021 NCQA child Medicaid national averages.
▲ Indicates the 2022 score is statistically significantly higher than the 2021 score.
▼ Indicates the 2022 score is statistically significantly lower than the 2021 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

An evaluation of the CHIP population's 2022 scores to the 2021 NCQA child Medicaid national averages revealed the following summary results:

- The CHIP population scored statistically significantly higher than the national averages on one measure, *Coordination of Care*.
- The CHIP population did not score statistically significantly lower than the national averages on any of the measures.

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

- The CHIP population's 2022 scores were statistically significantly lower than the 2021 scores on two measures: *Rating of Health Plan* and *How Well Doctors Communicate*.

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 2021 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 4-15.[4-2]

Table 4-15—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 4-16 presents the QI Program aggregate's and each participating QI health plan's member experience ratings and 2022 top-box scores for the four global ratings.

Table 4-16—NCQA Comparisons: Global Ratings

Plan Name	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*
QI Program	★★ **61.6%**	★★★ **58.4%**	★ **65.1%**	★★★ **70.1%**
AlohaCare QI	★★ 59.8%	★★ 56.0%	★ 64.1%	★★★ 70.6%
HMSA QI	★★ 59.0%	★★ 56.8%	★ 61.8%	★★★★★ 75.9%
KFHP QI	★★★ 62.9%	★★★ 60.9%	★ 64.1%	★ 62.9%
'Ohana QI	★★ 60.2%	★ 53.6%	★★★ 71.5%	★★★ 71.9%

[4-2] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021*. Washington, DC: NCQA, September 2021.

Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
UHC CP QI	★★★★ 68.1%	★★★★★ 68.1%	★ 63.0%	★★★ 70.0%+
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.				

Table 4-17 presents the QI Program aggregate's and each participating QI health plan's member experience rating and 2022 top-box scores for the four composite measures and one individual item measure.

Table 4-17—NCQA Comparisons: Composite and Individual Item Measures

Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care
QI Program	★ **79.2%**	★ **75.8%**	★ **90.6%**	★ **84.7%**	★ **81.7%**
AlohaCare QI	★ 79.2%	★ 75.5%	★ 90.7%	★ 83.9%	★ 78.9%+
HMSA QI	★ 78.5%	★ 71.8%	★ 90.6%	★★ 87.5%+	★ 79.4%+
KFHP QI	★ 79.6%	★ 78.9%	★ 90.6%	★ 85.1%+	★ 79.2%
'Ohana QI	★ 80.4%	★ 77.5%	★★ 91.7%	★ 83.6%	★★★★ 88.5%
UHC CP QI	★ 77.8%+	★ 74.5%+	★ 88.1%	★ 83.6%+	★ 81.2%+
+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.					

Comparison of the 2022 QI Program's scores to the 2021 NCQA adult Medicaid Quality Compass data revealed the following:

- The QI Program did not score at or above the 90th percentile on any of the measures.
- The QI Program scored below the 25th percentile on six measures: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.

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.

- UHC CP 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*.
- No QI health plans' member experience ratings met or exceeded the 75th percentile for *How Well Doctors Communicate*.

NCQA Comparisons—CHIP

Table 4-18 presents the Hawaii CHIP population's member experience ratings and 2022 top-box scores for the four global ratings, four composite measures, and one individual item measure.[4-3]

Table 4-18—NCQA Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	72.3%	★★
Rating of All Health Care	68.9%	★
Rating of Personal Doctor	79.5%	★★★
Rating of Specialist Seen Most Often	71.8%+	★★
Composite Measures		
Getting Needed Care	80.8%	★
Getting Care Quickly	83.1%	★
How Well Doctors Communicate	94.4%	★★★
Customer Service	90.0%+	★★★
Individual Item Measure		
Coordination of Care	92.6%+	★★★★★

Please note: CAHPS scores with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting these results.
Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Comparison of the CHIP population's scores to the NCQA's 2021 Quality Compass Benchmark and Compare Quality Data revealed the following:

[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.

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

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 (2021) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, CAHPS, Provider Survey, and encounter data validation (EDV). 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 five QI health plans and CCS completed the CAPs in 2021. CY 2022 began a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program.

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. 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

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.

Improvement Activities Implemented

Not applicable.

2021 HEDIS Performance Measure 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 setting, 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 that 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*

Improvement Activities Implemented

Childhood Immunization Status—The pandemic continues to play a role in decreased vaccination rates from both limited well-child visits and vaccine misinformation. AlohaCare QI, along with the other MCOs, has developed a vaccine hesitancy training that will be provided to 400 primary care physicians by year end. This training focuses heavily on motivational interviewing to understand member hesitancy to vaccines. AlohaCare QI developed vaccination materials to be offered to providers and mailed to member homes. Multiple campaigns have gone out in 2022 focusing on pediatric vaccination, coronavirus disease (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 QI undertook an omni-channel approach to improve outreach and communication. Automated campaign messages via text and interactive voice recordings (IVR) were used to educate and remind parents/legal guardians about well child visits and vaccinations listed above. Live telephonic calls were made to assist with scheduling visits.

AlohaCare QI continued a member incentive program to target noncompliant members eligible for these measures, and in March 2021 AlohaCare rolled out its Provider Pay for Performance Program, which included incentives for well-child visits and childhood immunizations. In addition, AlohaCare QI continued to focus on work to promote EPSDT, and AlohaCare QI's EPSDT coordinator provided extensive outreach to encourage pediatric visits that would include screening, vaccination and exams.

Finally, AlohaCare QI has attempted to set up a data feed with the Hawaii Immunization Registry but has been unsuccessful in that approach. AlohaCare QI believes that having more data related to vaccine status will help AlohaCare QI to target efforts to those who are truly non-compliant versus those who may have data gaps. In lieu of the data feed, AlohaCare QI is collecting medical records from providers after the member turns 2 years old.

Cervical Cancer Screening—AlohaCare QI has implemented a number of efforts to improve its cervical cancer screening rates. First, AlohaCare QI has continued the member incentive program to encourage members to get a cervical cancer screening. Additionally, AlohaCare QI has several IVR, text, and mail campaigns to educate members on the importance of screenings. Additionally, AlohaCare QI developed an internal PIP focused on increasing cervical cancer screening for members assigned and attributed to West Hawaii Community Health Center (now Hawaii Island CHC). Specific texts messaging and outreach calls were done to offer assistance to schedule well woman exams. AlohaCare QI was able to increase the compliance of the target population by nearly 8 percent, but this only impacted the overall

rate by 0.55 percent. AlohaCare QI's focus for the remainder of the year is to target women who were due for a cervical cancer screening during the height of the pandemic. These are women AlohaCare QI believes can be impacted, as they have had screenings before and may have forgotten during the public health emergency.

Timeliness of Prenatal Care—Automated campaign messages via text and IVR have been 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 QI recently designed new educational materials related to women's health screenings, which are mailed out when the pregnancy is known by AlohaCare QI. The pay-for-performance and member incentive programs continue to include incentives for prenatal and post-partum care. The most significant work done to improve AlohaCare QI's prenatal care rates is through the partnership with Healthy Mothers Healthy Babies (HMHB). AlohaCare QI coordinates with HMHB for outreach to all pregnant members to schedule prenatal care appointments with either their midwife, or to another obstetrics provider. HMHB also identified social determinants of health (SDoH) concerns with these members and connection them to community resources to assist. Despite these efforts, AlohaCare QI's rates continue to lag behind prior years, though improvement has been seen in postpartum care. AlohaCare QI is continuing to explore ways to engage pregnant members in ongoing care.

Comprehensive Diabetes Care—A1c Testing—Automated campaign messages via text and IVR have been used to educate diabetic members about the importance of A1c testing. A1c control is part of AlohaCare QI's pay-for-performance and member incentive program. Additionally, AlohaCare QI worked with providers to schedule appointments for diabetic members who have not had an A1c test yet in 2022. AlohaCare QI is in the process of revising the disease management program to specifically address diabetes education and follow-up for diabetic and pre-diabetic members.

Follow-up After Hospitalization—30 days—AlohaCare QI's focus for 2022 has been to find a new community behavioral health provider to increase follow-up for AlohaCare QI members. AlohaCare QI completed a PIP in 2020 with Care Hawaii that was very successful. Unfortunately, due to administrative issues, Care Hawaii chose to leave the partnership. AlohaCare QI signed a contract with Community Empowerment Resources, which works with the hospital discharge planners to make contact with the member prior to discharge and schedule follow-up appointments. AlohaCare QI is confident this will improve the follow-up rates for both seven days and 30 days.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior recommendations. While the *HbA1c Testing, Timeliness of Prenatal Care,* and *Cervical Cancer Screening* measure rates improved during MY 2021 and are no longer ranking below the 25th percentile, AlohaCare QI should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS

2021 Recommendations

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 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*
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.

Improvement Activities Implemented

Getting needed care—Members from all MCOs across the state are experiencing delays in scheduling in-person care due to COVID infection levels in Hawaii continuing to trend up due to the high infection

rate of the Omicron Subvariant BA.2. In addition, monkeypox infection levels in Hawaii are starting to increase. AlohaCare QI Telehealth Services utilization has increased significantly since the beginning of January 2020.

- AlohaCare QI will add content to the member handbook on how a member should prepare for an office visit and reoccurring articles will be include in the member newsletters.
- AlohaCare QI has updated its provider reimbursements from a proprietary fee schedule to a Medicare-based fee schedule, which has improved the transparency of reimbursements. Primary care services have also been increased under the PCP Enhancement program.
  - Outreach is made to nonparticipating providers to improve access to specialists not currently contracted with AlohaCare QI.
  - Implemented an e-Consult payment, which is a provider value-added service and conducted via telephone or computer. This service is a peer-to-peer consultation between a PCP and a specialist regarding a specific patient, without the patient present.
  - Implemented Specialist VIP recognition program in response to community health center (CHC) encouragement to recognize specialists who routinely accommodate requests and referrals to evaluate and treat CHC-assigned patients.

Care coordination between PCP and other providers—AlohaCare QI conducts provider trainings on a semiannual basis during group sessions and during regular interactions with network providers that cover provider roles and responsibilities:

- For PCPs—Assess the member's healthcare needs and provides/directs the services to meet these needs in all aspects of care.
  - Coordinate/initiate referrals to specialty care services
  - Maintain continuity of care
  - Maintain the AlohaCare QI member's medical record
- For PCPs, specialists, and ancillary providers:
  - Assure emergency services are available 24/7
  - Provide backup coverage when unavailable during regular office hours
- To ensure continuity of care, providers provide patients an After-Visit Summary detailing what was covered during the visit, medication review and follow-up needed.

Health plan helpfulness—AlohaCare QI hired a director to oversee Customer Service who has realigned the department to improve its Training and Quality programs. AlohaCare QI has reviewed, modified, and communicated its policies and procedures (P&Ps), standard operating procedures (SOPs), and training curriculum to staff members. AlohaCare QI held refresher trainings and expanded its communications by adding team huddles. AlohaCare QI has also updated and had refresher trainings for knowledge application. Lastly, AlohaCare QI also overhauled the Quality program through daily, weekly, and monthly coaching.

Forms easy to fill out—After internal review, it was found that AlohaCare QI does not have forms that parents need to fill out for their children. AlohaCare QI believes that these forms may be from the providers or the MQD. AlohaCare QI's health coordinators have been tasked with helping members fill out forms when needed.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed some of the prior recommendations; however, the health plan should continue to implement interventions to improve member satisfaction.

Provider Survey

2021 Recommendations

Based on the survey results, AlohaCare QI should focus efforts on improving the measures that were statistically significantly lower than the QI Program aggregate and measures that were lower than the 2018 top-box scores.

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*

Improvement Activities Implemented

Compensation Satisfaction—AlohaCare QI has updated its provider reimbursements from a proprietary fee schedule to a Medicare-based fee schedule, which has improved the transparency of reimbursements. AlohaCare QI reviews requests for fee increase from providers and negotiates reasonable rates that are mutually accepted.

Timeliness of Claims Payments—Please see response for this answer in the Encounter Data Validation section of this report.

Formulary—During 2021, AlohaCare QI was in the process of transitioning to a new pharmacy benefits manager (PBM). The provider survey results for Formulary dipped slightly, most likely because the survey was conducted during the first quarter of the transition from Express Scripts to IngenioRx. As with any change, providers were likely adjusting to the new formulary, where some preferred products became nonpreferred and vice versa. The transition to IngenioRx has been completed and AlohaCare QI expects the scores to return to baseline now that the change is complete.

Helpfulness of Service Coordinators—AlohaCare QI developed an Operations Tool that monitors key performance indicators (KPIs) regarding timelines for care coordinators to address members' needs and communicate members' needs effectively and timely with their providers. Additionally, AlohaCare QI implemented internal and external interdisciplinary team meetings (IDTs) on complex members in preparedness for hospital discharge, post-hospital discharge, and for other person-centered needs identified in the member's care or health action plan. AlohaCare QI also updated its policies and conducted additional training and retraining of staff to improve interactions with providers.

Adequate Network of Specialists

- All MCOs are impacted by the physician shortage among both primary care and specialty care.
- AlohaCare QI uses various reports such as GeoAccess reports and Network Adequacy reports to identify opportunities.
- Outreach is made to nonparticipating providers to improve access to specialists not currently contracted with AlohaCare QI.
- Implemented an e-Consult payment, which is a provider value-added service and conducted via telephone or computer. This service is a peer-to-peer consultation between a PCP and a specialist regarding a specific patient, without the patient present.
- Implemented Specialist VIP recognition program in response to CHCs' encouragement to recognize specialists who routinely accommodate requests and referrals to evaluate and treat CHC-assigned patients.
- AlohaCare QI has updated its provider reimbursements from a proprietary fee schedule to a Medicare-based fee schedule which has improved the transparency of reimbursements for specialists.

Availability of Mental Health Providers

- All MCOs are impacted by the physician shortage among both primary care and specialty care.
- AlohaCare QI uses various reports such as GeoAccess reports and Network Adequacy reports to identify opportunities.
- Outreach is made to nonparticipating providers to improve access to specialists not currently contracted with AlohaCare QI.
- AlohaCare QI has updated its provider reimbursements from a proprietary fee schedule to a Medicare based fee schedule, which has improved the transparency of reimbursements for specialists.

- Entered into an agreement with a telehealth network, which has allowed us to increase availability to a new mental health network.
- Entered into valued based contracts with Hawaii providers to provide follow-up mental health visits.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior recommendations; however, the health plan should continue to implement interventions to improve provider satisfaction.

Encounter Data Validation

2021 Recommendations

Based on the EDV study, the following areas for improvement were identified for AlohaCare QI:

- 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 5-1.
  - 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.[5-1] Lags in data submission could result in delayed analysis or incomplete or biased results.

Figure 5-1—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.

Improvement Activities Implemented

AlohaCare QI makes every effort to comply with the following request for proposal (RFP) requirements:

- Section 7.2 Health Plan General Responsibilities:

[5-1] 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.

- 4. Clean Claims Requirements.
  a) Clean Claims Requirements 4a. The Health Plan shall pay its Subcontractors and Providers consistent with the claims payment procedures described in Section 1902(a)(37)(A) of the Social Security Act. The Health Plans *shall allow providers at least one year from date of service or discharge, whichever is the latter, to submit claims for reimbursement*.
  b) The Health Plan shall pay ninety (90) percent of all clean claims *within thirty (30) days of the date of receipt of such claims; ninety-nine (99) percent of all clean claims within ninety (90) days of the date of receipt of such claims; and one hundred (100) percent of all clean claims within fifteen (15) months from the date of service.* The calculation of clean claim percentage paid is based on total clean claim count.

- Section 6.4 Encounter, A. 11. Encounter data shall be submitted to DHS, at a minimum, on a monthly basis, and no later than the end of the month following the month when the financial liability was processed, paid, denied, voided, or adjusted/corrected. *Health Plans shall submit one hundred (100) percent of encounter data within fifteen (15) months from the date of service, including all adjusted and resubmitted encounters*.

AlohaCare QI assumed that HSAG based their calculations for Figure 5-1—Percentage of Encounters Paid Within 180 Days, AlohaCare QI on the MQD encounter receipt date less the date of service.

While AlohaCare QI fully understands the need for accurate and timely processing of claims, the following situations do impact processing turnaround, which impacts encounter submissions:

- Providers have one year to submit claims to AlohaCare QI based on RFP requirements
- Patient has primary insurance delaying receipt and processing by AlohaCare QI
- AlohaCare QI's reprocessing of corrected claims received from providers
- AlohaCare QI's internal corrections due to incorrect payments or recoveries

Process improvement Activities Implemented:

AlohaCare QI monitors the following KPIs in the Medicaid program:

- Paper claim volume
- Electronic claim volume
- Percentage of claims processed with 7 calendar days
- Percentage of claims processed with 14 calendar days
- Percentage of claims processed with 30 calendar days
- Percentage of claims processed with 90 calendar days
- Percentage of claims processed with 455 calendar days (15 months)
- Percentage of claims adjusted
- Percentage of claims denied

- Days to scan paper claims
- Percentage of EDI claims
- Encounter acceptance rates based on paid claim amounts

Improvement activities include:

- Modifying existing reports to track encounter volume and acceptance rates by category (Professional, Inpatient, Outpatient, LTSS and Pharmacy).
- Modifying existing reports to track encounter turnaround times between service date and encounter acceptance date based on category (Professional, Inpatient, Outpatient, LTSS and Pharmacy).

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior recommendations; however, the health plan should continue to monitor encounter data completeness and timeliness and implement interventions to ensure encounter data is being reported to the State timely, completely, and accurately.

HMSA QUEST Integration (HMSA QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2021 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. This was a recommendation in the prior year as well.

Improvement Activities Implemented

HMSA QI began working with 'Ohana on the Behavioral Health PIP collaborative, to improve the quality of the CCS population data file for use in June 2022. Work is ongoing and status will be provided in the PIP submission.

2021 HEDIS Performance Measure 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*

Improvement Activities Implemented

Children Preventive Health

HMSA QI has partnered with IcarioHealth (formerly known as Novu) as an industry-leading healthcare partner to provide HMSA QI My Health Rewards. The program aims to engage HMSA QI members in their health and wellbeing journey by providing members with rewards when they complete one or more open healthcare activities, such as child well visits with immunization and prenatal and postpartum care.

Additionally, HMSA QI continues its two programs, Payment Transformation and Federally Qualified Health Center (FQHC) Pay-for-Quality, in which part of a provider's compensation is tied to specific quality metrics. This shifts the provider incentive from volume to value. These quality payment programs have historically included (and continue to include) a measure for childhood immunizations, which encompasses hepatitis B and all the vaccines that are grouped in combination 5 and 7.

Finally, as part of HMSA QI's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, on a monthly basis, HMSA QI sends members age-specific mailers that remind them to complete their well-child exams. These reminders include applicable vaccinations aligned to the Bright Futures screening and periodicity schedule.

Women's Health

HMSA QI has partnered with IcarioHealth (formerly known as Novu) as an industry-leading healthcare partner to provide HMSA QI My Health Rewards. The program aims to engage HMSA QI members in their health and wellbeing journey by providing members with rewards when they complete one or more open healthcare activities, such as child well visits with immunization and prenatal and postpartum care.

Additionally, HMSA QI continues its Pregnancy and Postpartum Support program, which pairs pregnant members with a maternity registered nurse (RN) for telephonic education and referrals. RN support is intended to complement and encourage regular prenatal and postpartum care. The program RN maintains contact with the member from enrollment through the first month after delivery. To improve

outreach to QI members, the program recently hired a dedicated QI nurse and is expanding its partnership with participating FQHCs to identify newly diagnosed pregnant members and offer additional resources. The Pregnancy and Postpartum Support program is also featured in advertisements in the summer and winter issues of HMSA QI's Island Scene magazine.

Care for Chronic Conditions

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

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

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

HMSA QI 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. While the *HbA1c Testing* and *Timeliness of Prenatal Care* measure rates improved during MY 2021 and are no longer ranking below the 25th percentile, HMSA QI should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS

2021 Recommendations

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 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*
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.

Improvement Activities Implemented

HMSA QI 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 HMSA QI members' experience with care in the delivery system. HMSA QI plans to evaluate trends in the survey results to evaluate any adjustments necessary to this process.

HSAG Assessment

HSAG has determined that HMSA QI has addressed some of the prior recommendations; however, the health plan should continue to implement interventions to improve member satisfaction. HMSA QI

should address the health plan-specific concerns identified by respondents that were related to customer service and health plan forms.

Provider Survey

2021 Recommendations

Based on the survey results, HMSA QI should focus efforts on improving the measures that were statistically significantly lower than the QI Program aggregate and measures that were lower than the 2018 top-box scores.

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.

Improvement Activities Implemented

Adequate Access to Non-Formulary Drugs

While HMSA QI's top-box score for *Adequate Access to Non-Formulary Drugs* was slightly lower than the QI Program aggregate, the bottom-box score was lower than the QI Program aggregate and lower than the 2018 bottom-box score. To ensure providers have adequate access to non-formulary drugs, HMSA QI closely manages its formulary, has simplified the formulary exceptions process, and has implemented several CVS Health technology-based innovation programs.

HMSA's QUEST Integration Formulary covers drugs across all therapeutic categories that have been reviewed and approved by a Pharmacy and Therapeutics Committee based on safety and efficacy. A drug's formulary status is based on scientific evidence, standards of practice, peer-reviewed medical literature, and accepted clinical practice guidelines. The formulary is managed, drives generic use, and uses over-the-counter products when possible. The formulary is also fortified with select brand drugs, which have been determined to be medically necessary when equivalent generic drugs are not available, or the brand drug offers better therapeutic outcomes or a more favorable safety profile. 99.64 percent of all prescriptions dispensed are for drugs that are on the formulary, which shows that HMSA's QUEST Integration Formulary represents a comprehensive list of drugs.

Providers may still access non-formulary drugs through the formulary exceptions process. The formulary exceptions criteria requires that a member try and fail at least two formulary alternatives. To minimize the administrative burden on providers, they can submit these requests electronically and they

are not required to submit documentation and paperwork. Instead, determinations are made based on provider attestation only.

HMSA QI also uses CVS Health technology-based innovations to help simplify the formulary exceptions process and improve access to non-formulary drugs for providers:

- Electronic prior authorization (ePA): ePA enables providers to obtain PAs in real time at the point-of-care and clinicians get approval or denial decisions within the electronic health records, often seconds after submitting a completed question set. This saves prescribers time by eliminating faxes and phone calls associated with manual PAs. ePA helps improve physician satisfaction and get the medications to members faster.
- Smart PA program: The Smart PA program relies on system rules to ensure PA criteria are met at the time of claim adjudication. The system reviews certain medical, lab, and pharmacy data to answer the clinical criteria. If the criteria are met, the claim pays with no member, prescriber, or pharmacy disruption. Other examples of Smart PA edits include:
  - Age: Claim pays if member meets certain age requirement
  - Diagnosis: Claim pays only for designated diagnosis
  - Gender: Claim pays only if member is a designated gender
  - Lab results: Claim pays only for designated lab results or medical procedure codes
  - Prescriber: Claim pays only for designated specialty providers or for providers who previously had a certain percentage of PA requests approved.
  - Step Therapy: Claim pays only if previous therapy has been tried
- Real-time benefits: To help prescribers and pharmacies connect with real-time information, HMSA uses Real Time Benefits across all points of care. This ensures more informed decision making and coordinated care, minimizes the provider administrative burden, and improves the member experience.
- Point of prescribing: Before a prescription is generated in the electronic health record system, the prescriber will have the following member-specific information immediately available at their fingertips, including:
  - Cost of the medication.
  - If a prescriber is submitting a prescription for a non-formulary medication, up to five clinically appropriate therapeutic alternatives will be provided based on the HMSA QUEST Integration Formulary.
  - Restrictions on the selected drug, such as prior authorization, step therapy requirements, or quantity limits.
  - Whether the selected pharmacy is in the network.
  - At the pharmacy: If the member's prescription is not covered, the pharmacist is alerted within the workflow and can request a prescription change from the prescriber at the click of a button. The pharmacist will also see the same list of clinically appropriate formulary alternatives.
  - Connecting members: Through the Check Drug Cost tool on HMSA.com and the Caremark app, members can now:

  - Find out if their medication is covered.
  - See the cost of their medication and up to five clinically appropriate, therapeutic formulary alternatives if their medication is not covered.
  - See coverage restrictions, such as prior authorization or quantity limits.
- NovoLogix: NovoLogix is a Web-based PA tool for HMSA QI providers that supports the submission and online approval of PA requests for medical specialty drugs. Online PA saves providers time and eliminates the need to phone or fax PA requests for medical specialty drugs. Providers can track their PA status and view determinations in NovoLogix.

In addition to these technology-based innovations, HMSA QI has a Pharmacy PA Workgroup that reviews monthly PA data for trends and areas of opportunities to improve the member and provider experiences. Based on trends seen in PA approvals and appeals information, the Pharmacy PA Workgroup provides recommendations for formulary coverage, PA criteria, and utilization management opportunities. This process has resulted in drugs being added to the formulary and the formulary exceptions criteria being updated to ensure providers have adequate and easy access to non-formulary drugs.

Helpfulness of Service Coordinators

HMSA QI's top-box score for *Helpfulness of Service Coordinators* was slightly lower than the QI Program aggregate and slightly lower than the performance in the same measure in 2018. To address the slight decline in provider's rating on the adequacy of the help provided by HMSA QI's service coordinators, HMSA QI identified an opportunity to improve communication of a provider's patient participation in HCS and the services they are receiving.

Currently, PCPs can access service plans for their members through HMSA QI's provider portal Hawaii Healthcare Information Network (HHIN). From past conversations with PCPs and physician leaders, HMSA QI found that many PCPs are not aware of this convenient feature. Therefore, HMSA QI created a letter campaign with a refresher of the HCS program benefits and how to access information on their member's through HHIN. HMSA QI has also been supplementing the letter with a 1:1 training of HHIN with key providers. One training with the Queen Emma Clinic in August of 2022.

HMSA QI will continue to gather input from its provider partners on how to best improve the helpfulness of service coordinators by collecting feedback on these interventions as well as through new suggestions that come from improved communication efforts such as this.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior recommendations; however, the health plan should continue to implement interventions to improve provider satisfaction.

Encounter Data Validation

2021 Recommendations

Based on the EDV study, the following areas for improvement were identified for HMSA QI:

- 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.

Improvement Activities Implemented

HMSA QI's research suggests the main driver behind the rendering/servicing provider NPIs in encounters not being found in the provider reference file was linked to services rendered outside of Hawaii (less than 4 percent of encounters). To resolve, HMSA QI has been working with a vendor and the MQD to align encounter-referenced provider data with the Med-QUEST Provider Master Registry (PMR), correct missing or inaccurate provider NPI records found on the PMR, and review encounters pended by the State for errors related to the provider data.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior recommendations; however, the health plan should continue to monitor encounter data completeness and implement interventions to ensure encounter data are being reported to the State timely, completely, and accurately.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2021 NCQA HEDIS Compliance Audit Recommendations

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.

Improvement Activities Implemented

Not applicable.

2021 HEDIS Performance Measure 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*

Improvement Activities Implemented

Care for Chronic Conditions—*Comprehensive Diabetes Care*

- In 2022, Kaiser Permanente (KP) continued efforts to address comprehensive diabetes care by addressing care gaps during routine/urgent visits as well as through Worksite Care Gap clinics. Additionally, KP sends out "birthday cards" indicating care gaps due for that member.
- Diabetes Eye Screening project implemented at multiple primary care clinics.
- Comprehensive disease management programs include interventions for:
  - Low-risk patients who have diabetes mellitus (DM) interventions delivered by their primary medical care team, which may include registered dieticians and certified health coaches.
  - Moderate-risk patients who need additional care management interventions led by chronic disease management nurses and clinical pharmacists.
  - High-risk patients that include personal case managers and care coordinators who are clinical pharmacists, chronic disease management nurses, or advanced nurse practitioners.
- Recent Type 2 Diabetes Population Health strategies:
  - Shorter A1c recheck interval to monitor and encourage patients actively engaged in medication initiation and/or titration.
  - Use of health coaching and registered dieticians to maintain patients in good control as well as targeting patients who are slipping out of control.
  - "Health Achieved Through Lifestyle Transformation" pilot program initiated.
  - Care managers working closely with medical doctor (MD) and meet with patients at their clinic appointments.
  - Targeting patients after hospitalization or after a diabetes class.
  - Use of remote glucose monitoring that allows blood sugar readings to sync directly to the medical record for care manager review.

- Smarter outreach with letters and emails in addition to live calls.
- Automated reminders to download/email blood sugars.
- Medication adherence outreach for patients overdue for refills, encouraging 90 days supplies and mail order with less copays.

Behavioral Health—*Follow-Up After Hospitalization for Mental Illness*

- As a result of the PIP related to this measure, the behavioral health department continues to make reminder calls for members with post-hospital appointments, both virtual and face-to-face visits.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior recommendations. All five of the measure rates ranking below the 50th percentile in MY 2020 are ranking in the 50th percentile or higher for MY 2021. The health plan should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS

2021 Recommendations

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 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*
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**
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.

Improvement Activities Implemented

- *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 Convenient Care campaign includes Get Care Now, a feature that has been implemented in 2022. It allows members to have 24/7 on-demand virtual urgent care. Chat With a Nurse is also part of the campaign and allows KFHP QI members to speak with a nurse via chat message. E-tickets and e-visits have been expanded, and work continues to be done to improve appointment conversion rates in kp.org. Lastly, data continue to be collected to determine how KFHP QI's urgent care models can improve. KFHP QI continues to focus on improving access to care that is convenient for KFHP QI members by optimizing easy to use online care options via kp.org or by calling in to the appointment call center.
- *Respondents reported that it was often not easy for their child to obtain appointments with specialists.*
  As an integrated system, Kaiser Permanente Hawaii (KPHI) has the internal network and resources to provide pediatric specialty care for its pediatric population. KFHP QI's PCPs continually partner with specialty providers to ensure that there is appropriate access to services for KFHPQ QI members. However, there are situations that require KFHP QI to refer patients to specialists in the community, which may be limited, especially on neighboring islands. This requires KHFP QI's healthcare team to continue outreach with these community providers to ensure that KHFP QI's patients receive access to care.
- *Respondents reported that their child's personal doctor did not always spend enough time with them.*
  Caring and compassion are core values of KFHP QI's provider practice and set the standard for the member experience. KFHP QI will continue to monitor these ratings to ensure continued positive and consistent member experiences.
- *Respondents reported that forms from their child's health plan were often not easy to fill out.* KFHP QI's 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, implementing pre-visit questionnaires, and reviewing forms with KFHP QI's Patient and Family Centered Care Advisory Council for ease and understanding.

HSAG Assessment

HSAG has determined that KFHP QI has addressed some of the prior recommendations; however, the health plan should continue to implement interventions to improve member satisfaction.

Provider Survey

2021 Recommendations

Based on the survey results, KFHP QI should focus efforts on improving the four top-box scores that were lower in 2021 than in 2018:

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

Improvement Activities Implemented

The following explanations address the areas of the Provider Survey that were less favorable than the previous survey done in 2018:

Formulary

Calendar year 2021 was a challenging year due to the pandemic and many drug shortages due to supply chain manufacturing problems. Providers may have felt that KFHP QI's typical formulary medication not being in stock and having to change the member to an alternative medication. If shortages are lasting more than two weeks, decision support is built to alert the prescriber and suggest alternatives.

Helpfulness of Service Coordinators

Churn of providers (retirement, relocation, etc.) may be a contributing factor to the increased Neutral rating and new providers may not have had the opportunity to interact with KFHP QI's Health Coordination Team. The Health Coordination Team continues to partner with the QI medical directors for provider education and communication and participates in new provider orientation sessions to inform providers on the availability of the team. With the pandemic, the orientations were conducted virtually and are now going back to in-person meetings.

Response time to providers' requests for service coordination may have been impacted by various factors, including increased Medicaid membership, increase in health coordination referrals, loss of health coordinators and support staff, as well as increase in caseloads and administrative burden for the health coordinators. KFHP QI is in the process of hiring temporary contract staff to allow care coordination staff with increased bandwidth to work on HFAs and will shift administrative work from licensed to non-licensed Health Coordination staff.

Adequate Network of Specialists

KFHP QI continues to utilize various external and internal reports to gain perspectives around access to care with the various modalities of providing care:

- External—Medicare 5 Star, Hospital CAHPS (HCAHPS), Medicare Advantage and Prescription Drug Plan CAHPS (MCAHPS), social media, and Web search reports
- Internal—specialty and primary care access, diagnostic imaging
- Interregional—Permanente Access Leadership Council access reports, integrated behavioral health, trended access
- Complaints, Grievances, and Appeals Report

The KP Market Access Team was created to highlight, prioritize, and standardize monitoring of access and availability. Monthly review of access reports is completed at multiple levels within the organization from the executive level to frontline operations to uncover the root cause of any issues and then follow with actionable solutions accompanied by realistic implementation timelines.

The MQD quarterly Network Adequacy Report identifies gaps in the network, including specialists. The report has been modified to represent need based on actual member demographics and utilization rather than just the number of providers available in the geographical area.

Example of interventions completed/in-progress to meet an identified gap in access for optometry.

- Expansion of hours beyond normal clinic hours into evening and weekend
- Shifting physician resources between islands and between clinics
- Implementation of medical assistant-operated diabetic and retinal screen cameras in order to offload visits from the optometry schedules
- Provider recruitment—hired six optometrists in fall 2021 and continuing to recruit.

Availability of Mental Health Providers

As noted in Executive Summary of 2021 Hawaii Provider Survey report, overall for Hawaii, there has been "a 31% increase in the percentage of adults with frequent mental distress between 2011 and 2019" while also dealing with an overall provider workforce shortage that includes mental health providers. KFHP QI has developed a multi-year strategy to increase both internal and external capacity of mental health providers. Over the past year, KFHP QI has made progress in contracting with over 40 new behavioral groups with capacity to treat KFHPQ QI members with a strategy to add more over the next few years

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior recommendations; however, the health plan should continue to implement interventions to improve provider satisfaction.

Encounter Data Validation

2021 Recommendations

Based on the encounter data validation study, the following areas for improvement were identified for KFHP QI:

- 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 Medical Management Information System (MMIS), encounters from KFHP QI would be incomplete for downstream analyses.

Improvement Activities Implemented

Monitoring Timeliness

KFHP's QUEST Integration Administration Department is working with the National Medicaid Encounter Reporting team to explore methodologies for:

- Monitoring timeliness based on the date of service and payment date, as well as monitoring timeliness over time; and
- Adding more metrics to actively monitor encounter data completeness and accuracy before submitting files to MQD.

Pharmacy Encounters

KFHP QI currently monitors monthly submissions for the National Council for Prescription Drug Programs (NCPDP) and medical encounters as part of the overall monitoring of encounter submissions.

Claims Payment

KFHP QI updated NCPDP criteria to meet the RFP requirements 6.4.11—Encounter data shall be submitted to DHS, at a minimum, on a monthly basis, and no later than the end of the month following the month when the financial liability was processed, paid, denied, voided, or adjusted/corrected—and began submitting the files in August 2021.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior recommendations; however, the health plan should continue to monitor encounter data completeness and timeliness and implement interventions to ensure encounter data is being reported to the State timely, completely, and accurately.

'Ohana Health Plan QUEST Integration ('Ohana QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2021 NCQA HEDIS Compliance Audit Recommendations

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.

Improvement Activities Implemented

Not applicable.

2021 HEDIS Performance Measure 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*

Improvement Activities Implemented

2022 Medicaid Partnership for Quality (P4Q) Program

- 'Ohana QI's 2022 Medicaid Partnership for Quality (P4Q) recognizes providers who deliver high quality care. Through the P4Q program, providers are able to obtain financial incentives to close care gaps addressing preventive care and chronic conditions. 'Ohana QI supports providers by educating them about the program, providing quality performance meetings 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. Childhood immunizations, well-child visits, cervical cancer screening and diabetes A1c testing/control are included in the measures that are incentivized.

2022 My Health Pays

- 'Ohana Health Plan provides incentives to members, in the form of visa cards, for completing healthy behaviors including annual wellness visits, well-child visits, cervical cancer screening, breast cancer screening, prenatal/postpartum care and diabetes A1c testing. The visa cards can be used to pay for everyday items at Sam's Club, Walmart, and can also be used to pay for utilities, rent, transportation and childcare.

Focused Call Campaigns

- 'Ohana QI'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. Focused campaigns throughout 2022 included outreach for well-child visits and postpartum follow up. If the PPC is unable to reach the member by telephone after multiple attempts, an unable to contact letter for established patients is sent that identifies services that are overdue and asks the member to contact their PCP (name and phone number included in the letter). The letters also include information about how to schedule transportation and includes 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 the member with information regarding how to change their PCP if needed.

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. While ‘Ohana QI showed improvement in the *Comprehensive Diabetes Care—HbA1c Testing* measure rate in MY 2021, all Childhood Immunization Status measure rates and the *Cervical Cancer Screening* measure rate decreased from MY 2020 to MY 2021.

CAHPS

2021 Recommendations

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 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*
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		✓	✓
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 always 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.

Improvement Activities Implemented

Mock CAHPS Results

'Ohana QI distributed mock CAHPS reports to providers whose patients responded to the mock survey. The report results highlighted opportunities for providers to improve adult and child care coordination.

Hallmark Cards

This initiative aimed to connect with 'Ohana QI members in a more meaningful way and have 'Ohana QI be viewed as a more of a "trusted friend/partner" in a members healthcare journey.

Below are images of the front and back of the Hallmark card, along with the inside message. The notion is to build stronger member relationships and an "emotional connection" to 'Ohana QI in order to move members to take action through sending a Hallmark card, which is one of the most highly recognized brands nationwide. A Hallmark card from 'Ohana QI should be more like receiving a card from a caring friend versus the prescriptive tone usually conveyed by a letter or mailing from a health plan.

Multiple mailouts of the cards were deployed in 2022. Accompanying each card was one of four MQD/State-approved inserts for 'Ohana QI's membership addressing various topics such as well child visits, talking to your PCP, annual wellness visits, and member incentives/rewards for healthy behaviors.

HSAG Assessment

HSAG has determined that ‘Ohana QI has addressed some of the prior recommendations; however, the health plan should continue to implement interventions to improve member satisfaction. ‘Ohana QI should address the health plan-specific concerns identified by respondents that were related to customer service and health plan forms.

Provider Survey

2021 Recommendations

Based on the survey results, ‘Ohana QI should focus efforts on improving the measures that were statistically significantly lower than the QI Program aggregate and measures that were lower than the 2018 top-box scores.

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*

Improvement Activities Implemented

Compensation Satisfaction

- ‘Ohana QI previously paid out the enhanced rates for eligible PCPs and codes as part of a quarterly reconciliation process. As of October 1, 2021, for claims dates of service on or after October 1, 2021, ‘Ohana QI incorporated the enhanced rate into the fee for service (FFS) payment when the claim is processed.
- ‘Ohana QI previous process to review inpatient readmissions for possible avoidable readmissions within the past 30 days was reviewed on a pre-pay basis, which meant ‘Ohana QI would identify which claims were most likely avoidable or preventable readmissions and deny these claims, notifying the provider of their right to dispute or appeal the determination. Upon multiple provider requests to help ease the burden of not receiving payments timely and to align ‘Ohana QI’s policy with other health plans, starting October 1, 2022, ‘Ohana QI changed its inpatient readmission review policy to pay providers at the time their claim is processed. After payment is made, if identified as most likely an avoidable or preventable readmission, ‘Ohana QI will request a refund and notify the provider of their right to dispute or appeal the determination.

Timeliness of Claims Payments

- ‘Ohana QI’s leadership team implemented a weekly prioritization meeting with the Claims Operation Account Management team to not only review/prioritize provider disputes, but to identify areas of opportunity to be proactive and contain the issue when addressed, thereby avoiding any future provider abrasion or delays in claims payments.
- Fully staffed the Operations Account Management team, thereby allowing ‘Ohana QI to focus on meeting standard level of agreements for disputes and escalations, decreasing the time frame between dispute and resolution/claims payment.

Adequate Access to Formulary Drugs/Formulary

- ’Ohana QI conducts routine market analysis of its PDL (Preferred Drug List) vs. the MCO counterparts for Medicaid.
- ‘Ohana QI offers direct access to staff members when providers encounter barriers to medication coverage including but not limited to denials (for any reason), HOKU registration, assistance with prior authorizations, etc.
- ‘Ohana QI proactively reviews rejected claims reports by prescribing provider to analyze for opportunities to engage with providers and assist or educate them for future adjudication by the pharmacy, which in turn has allowed ‘Ohana QI to identify opportunities for enhancements.
- ‘Ohana QI continues to work on improving its frontline customer service lines/help desk assistance by focusing on education and training to improve provider satisfaction scores and medication access.

Prior Authorization Process

- Upon hearing providers' frustration with the number of prior authorizations they had to submit, the delays this caused in providing treatment to their patients as well as delays in receiving payments, 'Ohana QI created its Gold Card Program for qualified specialists who meet and maintain a low denial rate to no longer require prior authorizations for certain visits. Implementing this program is not only removing the administrative burden on the providers, while also allowing timely payment.
- 'Ohana QI worked with the other MCOs to develop a unified form for all prior authorization requests for all health plans; expected date of implementation January 1, 2023.

Adequate Network of Specialists

- 'Ohana QI is continuously looking for specialists to recruit into the network from an online inquiry form, non-par specialist authorization and SCA requests, and true prospects from Clarify and Quest Analytic reports.
- 'Ohana QI offers the above-referenced Gold Card Program to specialists as an incentive to join the network.

Availability of Mental Health Providers

- 'Ohana QI now offers APRN-Rx providers enhanced rates if they stay open panel.

Access to Substance Abuse Treatment

- 'Ohana QI partnered with Hawaii Health and Harm Reduction Center (HHHRC) and Primary Plus to identify members with potential opioid misuse. 'Ohana QI's pharmacy team identifies these members and the Behavioral Health Case Management team will reach out to discuss any possible interest in substance use treatment through HHHRC. For those interested, 'Ohana QI sends a referral to HHHRC, and members enroll into the substance use treatment program, where established guidelines are set to manage evaluation, treatment, and continuous reassessment for 'Ohana QI members with substance use disorder, focusing on opioid use disorder.

HSAG Assessment

HSAG has determined that 'Ohana QI has addressed the prior recommendations; however, the health plan should continue to implement interventions to improve provider satisfaction.

Encounter Data Validation

2021 Recommendations

Based on the encounter data validation study, the following areas for improvement were identified for 'Ohana QI:

- 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 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 (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 5-2.
  - 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.[5-2] Lags in data submission could result in delayed analysis or incomplete or biased results.

Figure 5-2—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.

Improvement Activities Implemented

'Ohana QI has implemented an encounter submission report that measures claim aging in real time. The report currently gives a view by date of service and shows aging buckets starting from 30 days. 'Ohana QI can also utilize this report to trend timeliness by month, quarter, and year. 'Ohana QI is in the process of modifying this report to show an additional view to measure from payment date and to include resubmissions.

Additionally, 'Ohana QI utilizes the following reports to help measure timeliness and completeness of data.

[5-2] 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.

- 'Ohana QI has an 'End to End' report that tracks each claim from payment through to the encounter system. This ensures that all claims are received by the encounter system to process
- 'Ohana QI has a 'Completeness' report that measures the completeness from the encounters system to State acceptance

For HIPAA data accuracy, 'Ohana QI utilizes Edifecs to validate HIPAA syntax and code sets on the claims received from the provider. Edifecs utilizes CMS sources to validate diagnosis, HCPCS, CPT, DME, and NDC code sets.

HSAG Assessment

HSAG has determined that 'Ohana QI has addressed the prior recommendations; however, the health plan should continue to monitor encounter data completeness and timeliness and implement interventions to ensure encounter data is being reported to the State timely, completely, and accurately.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2021 NCQA HEDIS Compliance Audit Recommendations

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.

Improvement Activities Implemented

Not applicable.

2021 HEDIS Performance Measure 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*

Improvement Activities Implemented

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

- UHC CP QI in partnership with other QI health plans developed and posted vaccine hesitancy training on its public website: "Vaccine Hesitancy: How to Identify and Approach the Movable Middle." In consultation with MQD, UHC CP QI is collaborating with other QI health plans to update the training to focus on motivational interviewing and using culturally competent techniques to address vaccine hesitancy in the community. UHC CP QI will promote the updated training to its providers through year-end.
- UHC CP QI has a Member Rewards Program that offers eligible members a gift card as a reward for closing a care gap. The program includes a reward for childhood immunizations. UHC CP QI raised the reward amount in 2021 (from 2020) to improve participation in the program. Eligible members are able to earn a reward by submitting a claim form online or by mail.
- UHC CP QI has an OmniChannel program that targets members with gaps in care, including childhood immunizations. The OmniChannel program performs member outreach using a member's preferred mode of communication: email, IVR calls, and/or text messages. The program is ongoing and runs year-round.
- UHC CP QI participates in a child immunization program sponsored by Pfizer. The program sends a reminder for missed dosed vaccines targeting parents or guardians of children at ages 6 months, 8 months, and 16 months. The reminders are completed using IVR calls and postcards. The program is ongoing and runs year-round.
- UHC CP QI published an article in the winter 2022 edition of the member newsletter (*HealthTalk*): "Vaccines save lives." The article explained the benefits of being vaccinated and encouraged members and their families to keep up to date on their immunizations.
- UHC CP QI hosted a wellness workshop for members: "Taking charge of your child's health." The workshop explained the importance of childhood vaccinations and included the schedule of recommended immunizations for children from birth through age 6 and from age 7 to 18 years old.
- UHC CP QI runs an ESPDT program for children and adolescents. The EPSDT program promotes EPSDT services (including immunizations) that align with Bright Futures screening and periodicity schedule. UHC CP QI deploys reminder mailers to help parents/guardians keep up to date on childhood immunizations. UHC CP QI also supports the MQD's EPSDT modernization efforts.

- UHC CP QI employs clinical practice consultants (CPCs) and an EPSDT coordinator who review the rate of childhood immunizations with providers. This occurs through review of patient care opportunity reports and/or at virtual or in-person meetings. UHC CP QI staff discuss improvement strategies with providers to raise childhood immunization rates. They also provide ongoing training as needed.

Women's Health

Cervical Cancer Screening

- UHC CP QI offers a Primary Care Professional Incentive program (CP-PCPi) to qualifying physician practices for performance tied to addressing patient care opportunities for certain HEDIS measures, including *Cervical Cancer Screening*.
- UHC CP QI's Member Rewards program also covers gap closures for cervical cancer screening. UHC CP QI raised the incentive amount in 2021 (from 2020) to improve participation in the program. Eligible members are able to earn a reward by submitting a claim form online or by mail.
- UHC CP QI's OmniChannel program also targets members with gaps in care for cervical cancer screening. The OmniChannel program performs member outreach using the member's preferred mode of communication: email, IVR calls, and/or text messages. The program is ongoing and runs year-round.
- UHC CP QI deploys an annual email campaign focusing on women's health. The email campaign encourages women to complete their yearly wellness exam and preventive screenings for both breast and cervical cancer.
- UHC CP QI created an Annual Care Checklist that includes preventive care screening guidelines and counseling services for women. The checklist includes recommended preventive care services such as cervical cancer screening (pap smear) as recommended by a doctor. UHC CP QI clinical staff share the checklist with members at home visits or as needed by email or mail.
- UHC CP QI's Member Handbook covers preventive healthcare for women. The Member Handbook includes a schedule for completing different types of cervical cancer screens depending on age (e.g., cervical cytology every three years starting at age 21). The Member Handbook also encourages members to ask their PCP if they are due for any tests or screenings.
- UHC CP QI employs CPCs who review the rate of cervical cancer screening with their assigned providers. This occurs through review of patient care opportunity reports and/or at virtual or in-person meetings. UHC CP QI staff discuss improvement strategies with providers to raise cervical cancer screening rates. They also provide ongoing training as needed.

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. All *Childhood Immunization Status* measure rates decreased from MY 2020 to MY 2021. While the *Cervical Cancer Screening* measure rate increased slightly in MY 2021, the rate is still ranked below the 25th percentile.

CAHPS

2021 Recommendations

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 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*
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.

Improvement Activities Implemented

UHC CP QI conducts CAHPS Medicaid adult and child surveys annually using an NCQA-certified HEDIS survey vendor. UHC CP QI reviews survey results at quality committees as part of continuous quality improvement. UHC CP QI created a CAHPS workgroup that is comprised of key operational and functional areas that have an impact on the member experience. The workgroup meets regularly to conduct barrier analysis and to develop and implement interventions to raise performance in areas of member experience such as access, customer service, and coordination of care.

Access to and Timeliness of Care

- UHC CP QI implemented UHC Doctor Chat, a telehealth platform that enables members to connect with a doctor online using a mobile application or web portal. Virtual visits are conducted on video with chat, audio, and image share available as part of the telehealth experience. UHC Doctor Chat is available to all UHC CP QI members.
- UHC CP QI developed a State-approved telemental health guide to help members connect with providers virtually. The guide explains in detail how to set up a telehealth appointment with a provider. UHC CP QI will partner with community-based organizations and providers to distribute the health guide to QI members.
- UHC CP QI hosted a wellness workshop for members: Taking charge of My Technology. The workshop explained how to use digital technology for telehealth/telemedicine. It also encouraged members to make use of online resources available such as MyChart and UnitedHealthcare Care Support.
- UHC CP QI created telehealth hubs, a dedicated space for members to complete a follow-up visit with a mental health provider following an inpatient hospitalization for mental illness. UHC CP QI offers the hub as a venue for members to complete a follow-up visit with a field care advocate and/or a community health worker. A gift card is offered as a reward for eligible members who complete a follow-up visit. UHC CP QI is transitioning its hub to a new location for better and more secure access to members when it becomes available.
- UHC CP QI posted the MQD joint health plan telehealth brochure (Stay Safe with Telehealth) on its public website with information on how and when to use telehealth. The brochure defines telehealth and encourages members to consider telehealth services as a health care option.
- UHC CP QI updated its provider directory to include a telehealth indicator for all network providers who offer telehealth or virtual visits as an option.

- UHC CP QI enhanced its information exchange process with its credentialing delegate to improve the credentialing and contracting experience for new providers. UHC CP QI is able to add new providers to its network more quickly as a result.
- UHC CP QI published an article in the spring 2022 edition of the member newsletter (HealthTalk): "Getting care—Know who to see and where to go." The article explained the role of the PCP in coordinating care and also provided instruction for when a member needs to see a provider right away, such as seeking care at an urgent care center.
- UHC CP QI deploys an annual email campaign focusing on telehealth/virtual visits. The email campaign educates members about telehealth and encourages them to "Get the care you need when you need it." The email also highlights behavioral health virtual visits as an option for members to receive care.
- UHC CP QI covers timely access to services in its Member Handbook. The Member Handbook explains acceptable wait times based on the type of appointment and type of visit needed (e.g., acceptable wait time for urgent care is within 24 hours). The handbook includes wait times for both medical and behavioral health appointments.

Quality of Care

- UHC CP QI is enhancing its customer service training program with an updated curriculum for new hires and uptraining for tenured staff. The enhancements include expanded customer service resources, updated training materials, and more hands-on training techniques.
- UHC CP QI hosts quarterly Member Advisory Group (MAG) meetings to solicit feedback from members on improvement opportunities related to various aspects of their healthcare experience. UHC CP QI regularly queries members at MAG meetings for their input on topics such as the value of telehealth or virtual visits and ways to improve their experience at their doctor appointment. UHC CP QI published an article in the spring 2022 edition of the member newsletter (HealthTalk): "Take charge—Prepare to see your provider." The article gave tips for how members can make the most out of their doctor appointments.
- UHC CP QI shares CAHPS results with physicians on its Provider Advisory Committee (PAC) to obtain feedback on improvement strategies to enhance the member experience at the doctor's office. An example of best practices shared at PAC include offering an after-visit summary following the appointment.
- UHC CP QI educates providers on cultural competency at its townhalls and in materials such as the Care Provider Manual and bulletins or newsletters. An important component of cultural competency training is how physicians can enhance communication by taking into account each member's language and cultural background.

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.

Provider Survey

2021 Recommendations

Based on the survey results, UHC CP QI should focus efforts on improving the measures that were statistically significantly lower than the QI Program aggregate and measures that were lower than the 2018 top-box scores.

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*

Improvement Activities Implemented

Compensation Satisfaction and Timeliness of Claims Payments

- UHC CP QI updated its fee schedules to align with CMS. When rate increases occur for Medicare, the same rate increase is applied to UHC CP QI's standard and enhanced Medicaid fee schedules.
- UHC CP QI expanded participation in its quality incentive programs (e.g. CP-PCPi) as an opportunity for providers to earn bonuses and increase revenue. UHC CP QI implemented Automated Clearing House (ACH)/direct deposit to enable more timely and more secure claims payments. UHC CP QI actively encourages providers to sign up for the ACH/direct deposit payment option so their claims can be paid seven to 10 days sooner than a standard payment through a virtual card. Additional information about the electronic payment option is available in the Care Provider Manual.
- UHC CP QI performs ongoing internal monitoring of claims payment turnaround times and performs root cause analysis to identify and resolve any claims delays.

Prior Authorization Process

- UHC CP QI developed an initiative to increase utilization of its automated or electronic prior authorization process. As part of the effort, UHC CP QI performs targeted education to high-volume

providers and conducts reeducation about its prior authorization process at all monthly operational meetings, joint operating committees, and town halls.

- UHC CP QI in partnership with other QI health plans helped develop a standardized prior authorization form to be used for the QI program. The fillable form can be used online by providers. The new, simplified form is projected to go live in January 2023. UHC CP QI will continue to support MQD simplification efforts to reduce administrative burden for providers.
- UHC CP QI has internal escalation processes in place to ensure that prior authorization requests are resolved timely, or as soon as requested by a provider. UHC CP QI complies with all timeliness requirements for prior authorization.

Formulary and Adequate Access to Non-Formulary Drugs

- UHC CP QI maintains a PDL on its provider website for providers to review at any time. The PDL is available in a machine-readable format and in hard copy. The Pharmacy and Therapeutics Committee meets quarterly to discuss new product selections, updates, and deletions to the PDL. UHC CP QI publishes quarterly bulletins each time the PDL is updated. Additionally, any issues that pertain to pharmaceutical selection and pharmacy program management are communicated in the quarterly newsletter that is distributed to physicians. The PDL updates are also shared with providers on its Provider Advisory Committee. UHC CP QI also allows for a 90-day supply of a wide range of medications. The 90-day supply drug list is available to providers as needed.
- UHC CP QI and its pharmacy benefit manager enable providers to submit pharmacy prior authorization requests online more quickly with CoverMyMeds. CoverMyMeds streamlines the medication prior authorization process, electronically connecting providers, pharmacists, and the health plan to improve time to therapy and decrease prescription abandonment with ePA.
- UHC CP QI holds recurring ePA adoption rate calls to improve the adoption of ePAs. Benefits of ePA include reduced member medication disruption, less burden on providers and pharmacies because of less time needed to submit a prior authorization request, and faster PA determinations, which give members access to their medications more quickly. UHC CP QI monitors and tracks ePA data and shares best practices to improve the process for the benefit of members and providers.
- UHC CP QI created an internal Prior Authorization Reduction Work Group that meets regularly to streamline or reduce prior authorizations for non-formulary drugs. The work group reviews data for the most requested products and classes, addresses pharmacy point-of-service messaging for preferred drugs, and addresses physician concerns related to prior authorization.

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 provider satisfaction.

Encounter Data Validation

2021 Recommendations

Based on the encounter data validation study, the following areas for improvement were identified for UHC CP QI:

- 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 5-3.
  - 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.[5-3] Lags in data submission could result in delayed analysis or incomplete or biased results.

Figure 5-3—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.

- Large volume of long-term care (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.

[5-3] 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.

Improvement Activities Implemented

UHC CP QI has weekly meetings consisting of various functional areas to review encounter rejects and/or pends as well as bypasses (i.e. encounters that have known issues/errors prior to submission). UHC CP QI conducts root cause analysis and takes steps to address root causes and improve data completeness and accuracy. For example, if UHC CP QI determines that an encounters issue is related to provider billing, then UHC CP QI conducts provider education through its provider advocates and other teams. If an issue is related to a claims processing edit, then UHC CP QI conducts staff training and/or updates existing Standard Operating Procedures. UHC CP QI is working on the suspended encounter data for submission with all corrections made to prevent rejections or returns in the error report.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior recommendations; however, the health plan should continue to monitor encounter data completeness and timeliness and implement interventions to ensure encounter data is being reported to the State timely, completely, and accurately.

‘Ohana Community Care Services (‘Ohana CCS)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

2021 NCQA HEDIS Compliance Audit Recommendations

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.

Improvement Activities Implemented

Not applicable.

2021 HEDIS Performance Measure 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*

Improvement Activities Implemented

Interventions for *Antidepressant Medication Management* acute and continuation for members included:

- Member newsletter
  - Q1 2022:
    - Depression and You—Article describes what depression is and symptoms, encourages readers to talk to their case managers if members think they have these symptoms.
    - Pharmacy benefits—Importance of having multiple insurance cards to pick up their medications to get their medication dispensed.
  - Q2 2022: Antidepressants—Importance of continuing to take antidepressant, as it may take few weeks for the medication to become effective.
- On to Better Health by Magellan Health launched in 2022—This program is an online self-help tool and resources, including Smart Screener online assessment and provides cognitive behavioral therapy for conditions including depression—helps member recognize signs and symptoms, challenges negative thoughts, and manages relapse.

Interventions for *Antidepressant Medication Management* acute and continuation for providers included:

- Provider education
  - Q2 2022—Developed and deployed depression screening management educational material to address proper coding, assessment, and management.
  - Q3 2022—Published communication for PCPs, who may be treating members who have depression but not seeing a behavioral health specialist, suggesting some behavioral health conditions (clinical situations) will warrant referring/consulting a behavioral health specialist, such as a member having suicidal thoughts, multiple emergency room visits and inpatient admissions for mental illness including depression, co-existing substance use or personality disorder, or unresponsive to first-line behavioral health therapeutics.

HSAG Assessment

HSAG has determined that ‘Ohana CCS has addressed the prior recommendations; however, the health plan should continue to implement interventions as the *Antidepressant Medication Management—Effective Acute Phase Treatment* measure rate is still ranking below the 25th percentile in MY 2021.

Appendix A. Methodologies for Conducting EQR Activities

Introduction

In CY 2022, 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
- Validation of network adequacy
- Validation of performance measures (i.e., NCQA HEDIS Compliance Audits)
- Validation of PIPs
- A survey of adult Medicaid members using the CAHPS survey
- A survey of a statewide sample of CHIP members using the child Medicaid CAHPS survey

For each EQR activity conducted in 2022, 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 reviewed during the current three-year compliance review cycle (2022 through 2024).

Table A-1—Three-Year Compliance Review Schedule

	Year One (2022)	Year Two (2023)	Year Three (2024)
Standard	**Review of Standards**		**CAP Review**
Availability of Services	✓		Review of Standards/Elements that received a *Partially Met* or *Not Met* score during the 2022 and 2023 reviews.
Assurances of Adequate Capacity and Services	✓		
Coordination and Continuity of Care	✓		
Confidentiality	✓		
Coverage and Authorization of Services	✓		

	Year One (2022)	Year Two (2023)	Year Three (2024)
Standard	**Review of Standards**		**CAP Review**
Enrollee Information	✓		
Enrollee Rights and Protections	✓		
Grievance and Appeal System	✓		
Provider Selection		✓	
Subcontractual Relationships and Delegation		✓	
Credentialing		✓	
Quality Assessment and Performance Improvement		✓	
Health Information Systems		✓	
Practice Guidelines		✓	
Enrollment and Disenrollment		✓	

HSAG divided the federal regulations into 16 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
Availability of Services	438.68 438.206 438.14 42 USC §1396o(a)
Assurances of Adequate Capacity and Services	438.207
Confidentiality	438.224 45 CFR parts 160 and 164, subparts A & E 45 CFR 164.404 45 CFR 164.408 45 CFR 164.410
Coordination and Continuity of Care	438.208
Coverage and Authorization of Services	422.113 431.211 431.213 431.214 438.14 438.114 438.210 438.3 438.404

Standard Title	Regulations Included
	42 USC §1396 Title V of ARRA 2009, §5006
Credentialing	438.214 42 CFR Part 455 Subpart B State-Determined Requirements NCQA Credentialing and Recredentialing Standards and Guidelines
Enrollment and Disenrollment	438.3 438.52 438.56
Health Information Systems	438.242
Grievance and Appeal System	438.228 438.400 438.402 438.406 438.408 438.410 438.414 438.416 438.420 438.424
Enrollee Information	438.10
Enrollee Rights and Protections	422.128 438.100 438.110
Practice Guidelines	438.236
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
Subcontractual Relationships and Delegation	438.230

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—through its EQRO contract with the MQD—conducted a compliance evaluation of the health plans and the CCS program health plan. For the 2022

EQR compliance monitoring activity, which began a new three-year cycle of compliance review activities, HSAG conducted a desk audit and an on-site review of the health plans to assess the degree to which they met federal managed care and State requirements in select standard areas.

The primary objective for HSAG's reviews was to provide meaningful information to the MQD and the health plans regarding the plans' compliance with requirements in eight select areas. HSAG assembled a team to:

- Collaborate with the MQD to determine the scope of the review, standards to be evaluated, scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the agenda for the on-site review.
- Provide technical assistance to the health plans for participating in the compliance review process.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the reports of its findings.

To accomplish its objective, and based on the results of its collaborative planning with the MQD, HSAG developed and used a standardized data collection tool and processes to assess and document each organization's compliance with certain federal Medicaid managed care regulations, State rules, and the associated MQD contract requirements. The review tool included requirements that addressed the following eight performance areas:

- Standard I—Availability of Services
- Standard II—Assurances of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Confidentiality
- Standard V—Coverage and Authorization of Services
- Standard VI—Enrollee Information
- Standard VII—Enrollee Rights and Protections
- Standard VIII—Grievance and Appeal System

Prior to the on-site portion of the review, HSAG also evaluated how each organization implemented a number of the requirements for certain managed care administrative functions by reviewing samples of the following:

- Appeal records
- Grievance records
- Service authorization denials
- Care/service coordination records for special health care needs members

The health plans were asked to prepare and provide a demonstration of their tracking and reporting systems for a number of managed care administrative functions related to the standards under review. This allowed HSAG to evaluate the soundness of the health plans' methods for data capture and reporting for select MQD-required reports. In addition, HSAG used observations gained from accessing each health plan's Medicaid website to assess a member's experience in using the posted member information and provider directory.

The information and findings that resulted from HSAG's review of standards and files will be used by the MQD and each health plan to:

- Evaluate the degree to which the health plan's operations are in compliance with the State contract and federal managed care requirements.
- Evaluate health plan organizational strengths and identify areas for improvement.
- Identify, implement, and monitor interventions to improve health plan compliance and the quality, accessibility, and timeliness of its services.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance monitoring and follow-up reviews, HSAG, in collaboration with the MQD, developed a customized data collection tool to use in the review of each health plan. The content of the tool was based on applicable federal and State laws and regulations and the QI health plans' and CCS' current contracts. HSAG conducted the compliance monitoring reviews in accordance with the CMS protocol, *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[A-1]

Pre-on-Site Review Activities included:

- Developing the compliance review tool, worksheets, and file review tools.
- Scheduling the on-site reviews and sending an introductory letter with a schedule of key dates to each health plan.
- Generating file review samples based on data universes submitted by each health plan.
- Developing and forwarding to each health plan the on-site review agenda.
- Preparing and forwarding to each health plan a customized desk review form and instructions for submitting the requested documentation to HSAG for its desk review.
- Providing the data collection (compliance review) tool to each health plan to help facilitate its preparation for HSAG's review.
- Conducting technical assistance via Webinar for the health plans. The assistance included a PowerPoint presentation outlining the documentation submission processes, HSAG's desk review

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Apr 21, 2022.

and on-site review processes, submission of documents for the file reviews, and expectations for logistics during the on-site review. HSAG answered questions during and after the technical assistance session and was available for further assistance via telephone and e-mail up to the date of each plan's on-site review.

- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents obtained from the health plans. This desk review process enabled HSAG reviewers to increase their knowledge and understanding of each organization's operations, identify areas needing further clarification, and begin compiling interview questions before the on-site review.
- Conducting a pre-onsite review of the selected appeal, grievance, service authorization denial, and care/service coordination files.

On-Site Activities during the reviews included:

- An opening session, with introductions and a review of the agenda and logistics.
- Interviews with the health plans' key administrative and program staff members.
- Observation of the select tracking and reporting systems the health plans were requested to demonstrate.
- A closing conference during which HSAG summarized its preliminary findings from the review.

HSAG reviewers documented their observations and findings for each health plan in the data collection (compliance review) tool. HSAG then analyzed the information to determine the health plan's performance for each of the individual requirements in the standards. HSAG rated each element as *Met*, *Partially Met*, or *Not Met* to document whether the health plans complied with the requirements. HSAG reviewers used the following scoring methodology for each requirement in the compliance review tool.

Met indicates full compliance, defined as both of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present; and
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but staff are unable to consistently articulate processes during interviews; or
- Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present, and staff have little or no knowledge of processes or issues addressed by the regulatory provisions; or

- For those provisions with multiple components, key components of the provision could be identified, and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance, regardless of the findings noted for remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the eight standards and an overall percentage-of-compliance score across the eight standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point); *Partially Met* (value: 0.50 points); *Not Met* (value: 0.00 points); and *Not Applicable* (value: 0.00 points); and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall compliance score across the eight standards by using the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing them by the total number of applicable requirements).

To draw conclusions about the health plan's strengths and weaknesses related to the quality and timeliness of, and access to, the care and service provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included for each health plan:

- Observations, demonstrations, interview responses, and file and document review findings regarding each health plan's performance in complying with the requirements.
- The scores assigned to the health plan's performance for each requirement.
- The health plan's total percentage-of-compliance score for each of the eight standards.
- The health plan's overall percentage-of-compliance score calculated across the eight standards.
- The actions required to bring the health plan's performance into compliance with the requirements that received a score of *Partially Met* or *Not Met*.

HSAG documented the overall strengths and opportunities for performance improvement based on its findings. Areas that were *Partially Met* or *Not Met* were also included in a required corrective action plan template for use by the health plan. HSAG prepared a draft report for each health plan that described the results of the compliance review. The reports were forwarded to the MQD and the applicable health plan for their review and comment. Following the MQD's approval of each draft report, HSAG issued the final reports to the MQD and the applicable health plan.

Description of Data Obtained

To assess the health plans' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by each organization, including the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures

- Program descriptions, work plans, and annual evaluations
- Management/monitoring reports related to the areas for review
- Provider manual
- Member handbook
- Other provider and member communications
- Staff training materials and attendance logs
- Records and files related to a sample of appeals, grievances, service authorization denials, and care/service coordination records

Additional information for the compliance review was obtained through interaction, discussions, observations, and interviews with each health plan's key staff members, and through demonstrations and presentations provided by the health plans.

Table A-3 lists the major data sources HSAG used in determining compliance with requirements by each health plan and the period to which the data applied.

Table A-3—Description of Health Plans' Data Sources

Data Obtained	Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation and interview information available to HSAG during the on-site review	July 1, 2021–May 6, 2022
Member appeal, grievance, service authorization denial, and care/service coordination files	July 1, 2021–December 31, 2021

At the conclusion of each compliance review, HSAG provided the health plan and the MQD with a report of findings and any required corrective actions. The plan-specific results are summarized in Section 3 of this report.

How Conclusions Were Drawn

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 in 2022 to one or more of those domains of care. Each standard may involve the assessment of 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

Compliance Review Standard	Quality	Timeliness	Access
Availability of Services		✓	✓
Assurances of Adequate Capacity and Services		✓	✓

Compliance Review Standard	Quality	Timeliness	Access
Coordination and Continuity of Care	✓	✓	✓
Confidentiality	✓		
Coverage and Authorization of Services	✓	✓	✓
Enrollee Information	✓		
Enrollee Rights and Protections	✓	✓	✓
Grievance and Appeal System	✓	✓	✓

Validation of Network Adequacy

Objectives

In CY 2022, the MQD requested that HSAG conduct a NAV analysis including a review of the PNA report and procedures, and administration of a PDSQ to all participating health plans.

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in CMS rule §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. CMS has not released this protocol as of January 2023. However, the tasks described in this document align with current federal regulations and will help prepare the MQD to meet the NAV requirements once the EQR protocol goes into effect. The five QI health plans and one PIHP participated in the CY 2022 NAV activities.

Figure A-1 describes HSAG's three main phases for the CY 2022 network adequacy tasks. The remainder of this document provides methodologic details for each phase.

Figure A-1—Summary of CY 2022 Network Adequacy Tasks

CY 2022 Network Adequacy Tasks		
Data Collection	**Synthesis & Analysis**	**Reporting**
• Requested and received provider data from the health plans • Requested and received PNA procedure and data collection	• Analyzed and summarized findings from the data structure questionnaire • Conducted review and analysis of PNA procedure and instructions	• Submitted recommendations and findings from the PNA review

• Prepared and submitted a provider data structure questionnaire to the health plans		

Technical Methods of Data Collection and Analysis

Provider Data Structure Questionnaire

HSAG submitted a brief PDSQ to the health plans to obtain targeted information regarding their provider data structure(s) and methods for classifying providers (e.g., methods for identifying PCP or mental health providers).

PNA Procedures and Instructions

To ensure a comprehensive understanding of the MQD's current PNA procedures and reporting, HSAG requested the MQD's documentation of the PNA process, including all current network adequacy standards for the health plans as part of the documentation and standards review. HSAG requested samples of ongoing network adequacy and validation reports produced by the health plans as part of their regular monitoring. HSAG used this information to review and provide feedback on the PNA instructions and process.

Description of Data Obtained

Provider Data Structure Questionnaire

The health plans submitted questionnaire responses that HSAG used to analyze the structure and layout of the health plans' available provider data.

How Conclusions Were Drawn

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 NAV activities in 2022 to one or more of those domains of care. Table A-5 depicts assignment of the activities to the domains of care.

Table A-5—Assignment of NAV activities to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
Provider Data Structure Questionnaire			✓
PNA Procedure Review			✓

Provider Data Structure Questionnaire

HSAG reviewed the PDSQ responses and supplemental documents supplied by the participating health plans and followed up with each health plan for clarifications as needed. HSAG compiled all questionnaire responses and supplemental documents into an Excel workbook deliverable for the MQD's reference. Summary findings related to the PDSQ are described in the body of this report.

PNA Procedure Review

HSAG reviewed the PNA instructions, templates, and health plan reports. HSAG provided the MQD with a summary of findings that included gaps, ambiguities, and other recommendations for clarifications. The analysis focused on areas that may be associated with lack of clarity in the instructions that may result in inconsistency in data submissions by the health plans. Additionally, HSAG provided recommendations for the MQD for additional opportunities to enhance the PNA procedure and clarify instructions given to the health plans.

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 2021 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-6—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

Performance Measure	QI	CCS	Methodology
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
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
Controlling High Blood Pressure	✓		Hybrid
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 and 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
Long-Term Services and Supports (LTSS)			
LTSS Comprehensive Care Plan and Update	✓		CMR[1]
LTSS Minimizing Institutional Length of Stay	✓		Admin
LTSS Shared Care Plan with Primary Care Practitioner	✓		CMR

* A lower rate indicates better performance.

** Indicates this measure is a State-defined, non-HEDIS measure.

[1] This measure was reported using the case management review (CMR) methodology.

^ 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 2021, Volume 5: HEDIS Compliance*

Audit: Standards, Policies and Procedures. The measurement period reviewed for the health plans was CY 2021 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) audit validation activities such as development of measure-specific worksheets, validation of sample frames for survey measures, a review of completed plan responses to the HEDIS Record of Administration, Data Management, and Processes (Roadmap), medical record review validation, supplemental data validation, source code review for non-HEDIS measures, planning for the virtual audit review, and preliminary rate review; (2) virtual audit review activities such as interviews with staff members, primary source verification, query review and inspection of dated job logs, and computer database and file structure review; and (3) follow-up and reporting activities including final rate review and submission of a final audit report.

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 and case management record data; data capture, transfer, and entry processes for membership data; data capture, transfer, and entry processes for provider data; medical record data abstraction processes; case management record review validation for the LTSS measures reported using the case management review methodology, 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-7—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 (ECDS) 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.

NCQA Category for Measure Audit Result	Comment
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 only 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 2021, 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.
- Supporting documentation for sample case management 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 2020 and to the previous year's rates, where applicable. Measure rates reported by the health plans, but not audited by HSAG in MY 2021, are not presented within this report. Additionally, certain measures do not have applicable benchmarks. For these reasons, the HEDIS MY 2021 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 2021. The MQD Quality Strategy targets for the QI population and CCS program are defined in Table A-8 and Table A-9. 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-8—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
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-9—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
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 health plans, 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-10.

Table A-10—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	✓		
Concurrent Use of Opioids and Benzodiazepines	✓		
Controlling High Blood Pressure	✓		
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓		
Antidepressant Medication Management	✓		
Behavioral Health Assessment	✓		
Follow-Up After Emergency Department Visit for Alcohol and 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	✓		
Long-Term Services and Supports (LTSS)			
LTSS Comprehensive Care Plan and Update	✓		
LTSS Minimizing Institutional Length of Stay	✓		
LTSS Shared Care Plan with Primary Care Practitioner	✓		

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.

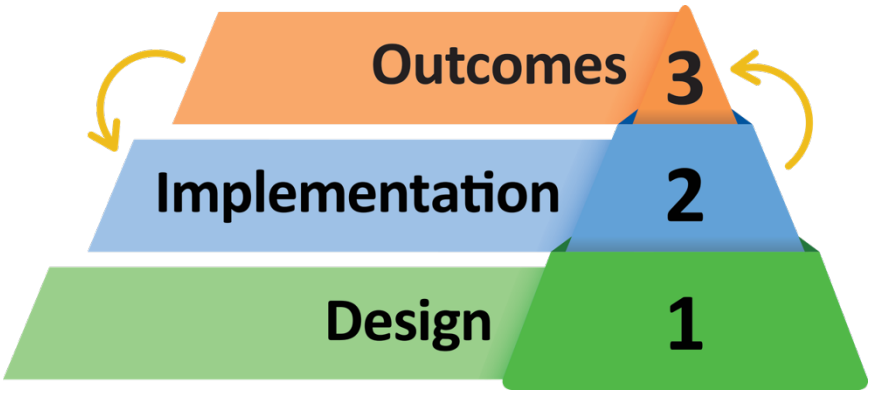
Technical Methods of Data Collection and Analysis

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]

Figure A-2 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage (Steps 1 through 6) establishes the methodological framework for the PIP. The steps in this section include development of the PIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP design is necessary.

[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: Feb 24 2023.

Figure A-2—Stages



Once a plan establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7 and 8). During this stage, the plan evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically, clinically, or programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline performance over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, plans should revise their causal/barrier analysis processes and adapt quality improvement strategies and interventions accordingly.

HSAG uses a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS Protocol 1. With the MQD's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS Protocol 1 steps:

Table A-11—CMS Protocol Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood That Significant and Sustained Improvement Occurred

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. Plans would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides *Validation Feedback* with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validations from the health plans' PIP Submission Forms. These forms provided detailed information about each health plan's PIPs. In 2022, the health plans submitted new PIPs and provided detailed information about the PIP design (Steps 1–6), provided baseline data (Step 7), and documented improvement strategies (Step 8) in the PIP Submission Forms.

The PIP topics that were validated in 2022 are included in Table A-12.

Table A-12—PIP Topics in 2022

Health Plan	PIP Topic
All QI health plans	• *Behavioral Health Coordination* • *Plan All-Cause Readmissions*
'Ohana CCS	• *Behavioral Health Coordination* • *Follow-Up After Emergency Department Visit for Mental Illness*

How Conclusions Were Drawn

HSAG's methodology for assessing and documenting PIP findings provides a consistent, structured process and a mechanism for providing the plans with specific feedback and recommendations for the PIP. Using its PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

Met = high confidence/confidence in the reported findings.

Partially Met = low confidence in the reported findings.

Not Met = reported findings are not credible.

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-13.

Table A-13—Assignment of PIPs to the Quality, Timeliness, and Access Domains

Performance Improvement Project	Quality	Timeliness	Access
Behavioral Health Coordination	✓	✓	✓
Plan-All Cause Readmissions	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓

2022 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

The primary objective of the Adult Medicaid CAHPS survey was to effectively and efficiently obtain information on the levels of experience with the Hawaii adult 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 Adult CAHPS survey and the CHIP CAHPS survey was accomplished through administration of the CAHPS 5.1H Adult Medicaid Health Plan Survey to adult 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. Adult members included as eligible for the survey were 18 years of age or older as of December 31, 2021. CHIP members included as eligible for the survey were 17 years of age or younger as of December 31, 2021. All members (or parents/caretakers of sampled CHIP members) completed the surveys from February to May 2022 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 nonrespondents, followed by a second survey mailing, a second reminder postcard, and CATI. It is important to note that the CAHPS 5.1H Adult Medicaid Health Plan Survey is made available by NCQA in English and Spanish only.[A-3] 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 adult members the option to complete the CAHPS survey in the designated alternate languages.[A-4]

The adult CAHPS survey included a set of standardized items (40 questions) that assessed members' perspectives on their care. The CHIP CAHPS survey included a set of standardized items (41 questions) that assessed parents'/caretakers' perspectives on their child's care. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed to select the adult 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 adult and child Medicaid CAHPS survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[A-5] NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS survey result; however, for this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

The survey questions were categorized into 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 respondents' overall experience with the health plan, health care, 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

[A-3] 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 Adult Medicaid Health Plan Survey is made available by NCQA in English, Spanish, and Chinese only. The standard Chinese translation for the adult Medicaid CAHPS survey can only be used for the mail survey protocol. NCQA's approval of this survey protocol enhancement was required in order to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.

[A-4] National Committee for Quality Assurance. *HEDIS® Measurement Year 2021*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2021.

[A-5] Ibid.

defined as a response of "Usually" or "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 2021 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 percentile distributions shown in Table A-14.

Table A-14—Star Ratings

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

Additionally, HSAG performed a trend analysis of the adult Medicaid and CHIP results. The adult Medicaid 2022 scores were compared to their corresponding 2020 scores, and the CHIP 2022 scores were compared to their corresponding 2021 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 adult 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

[A-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2021*. Washington, DC: NCQA, September 2021.

[A-7] The adult Medicaid population was last surveyed in 2020; therefore, the 2022 adult Medicaid CAHPS scores are compared to the corresponding 2020 scores.

plan's top-box score that was not statistically significantly different than the QI Program aggregate is not denoted with an arrow.

Also, HSAG compared each of the adult Medicaid QI health plan's and the QI Program aggregate's 2022 scores to the 2021 NCQA adult Medicaid national averages, and CHIP's 2022 scores to the 2021 NCQA child Medicaid national averages.[A-8] Scores that are statistically significantly higher than the 2021 NCQA adult and child Medicaid national averages are represented by yellow highlighted cells. Scores that are statistically significantly lower than the 2021 NCQA adult and child Medicaid national averages are represented by red highlighted cells. These comparisons are performed for the four global ratings, four composite measures, and one individual item measure.

Also, HSAG performed a key drivers of member experience analysis of the adult Medicaid and CHIP populations for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. HSAG evaluated each of these areas to determine if specific CAHPS items (i.e., questions) are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers," may be driving respondents' level of experience with each of the three measures; therefore, the key drivers of member experience analysis help 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 respondents' overall experience.

Description of Data Obtained

The CAHPS survey asks respondents to report on and evaluate their experiences with their/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 2022. 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. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), had a language barrier, or were mentally or physically incapacitated (adult CAHPS survey only). Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the adult and child CAHPS surveys, HSAG provided the MQD with plan-specific reports and a statewide aggregate report of the adult Medicaid results, as well as a statewide aggregate report of the CHIP survey results.

[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.

Plan-specific results of the adult CAHPS survey are summarized in Section 3 and CHIP results of the child CAHPS survey are summarized in Section 1 of this report. Statewide comparison results of each adult Medicaid QI health plan and the QI Program aggregate, as well as CHIP 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-15.

Table A-15—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	✓		